

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6484

## CERTIFICATE OF DEATH

Reg. Dist. No.

06460

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>9mths24dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <span style="float: right;">3V01-4</span>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>33 2242 Sidney Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Anna</b> Last <b>Ambrose</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>63</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 31, 19 57</b> to <b>June 2, 19 58</b> , that I last saw the deceased alive on <b>June 2, 19 58</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-2-58</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIED</b>	<b>19 JUNE 58</b>	<b>NEW CATHEDRAL</b>	<b>OLD FREDERICK RD MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Bachman</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 5 '58</b>	
ADDRESS <b>637 Washington</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06461

Reg. Dist. No.

6485

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, 28, Md.</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>2303 W. North Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Amolsky</b>				4. DATE OF DEATH Month <b>6</b> Day <b>18</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19, 1882</b>	
				9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Louis Amolsky</b>				14. MOTHER'S MAIDEN NAME <b>Kate Seigel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Spring Grove Hospital Catonsville, 28, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Artemia</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular disease</b> (c) <b>Dehydration Senility</b> DUE TO <b>Dehydration Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Geo. M. Kieffer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>GEO. S. M. KIEFFER MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 19/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friedndship</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>So. Leonard &amp; Mrs. 1124-26 W. North Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 19 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





m.Cook-Blight Inc 6009 Harford Road Baltimore Md

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6487

CERTIFICATE OF DEATH

Reg. Dist. 66463

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>				d. STREET ADDRESS <b>2259 Reisterstown Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>ELLSWORTH</b> Last <b>ATKINSON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8,</b> Year <b>19 58</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 3, 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motorman (rtd)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Transit Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>William R. Atkinson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Cook</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-10-1292</b>		17. INFORMANT <b>Mr. Walter B. Atkinson - 6746 Glenkirk Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum with</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>widespread metastases</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 19, 1958</b> to <b>June 7, 1958</b> that I last saw the deceased alive on <b>June 7, 1958</b> and that death occurred at <b>7:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2108 Euter Place - Baltimore 17 Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Morton M. Krieger</b>				M.D. <b>2108 Euter Place - Baltimore 17 Md.</b>			
PHYSICIAN'S NAME (Type) <b>MORTON M. KRIEGER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS - Balto. 17, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overhouch</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06464

6488

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>8026 Old Philadelphia Rd.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8026 Philadelphia Rd. Balto. Md.</b>				d. STREET ADDRESS <b>8026 Old Philadelphia Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Thomas Griffith Bamford</b>			4. DATE OF DEATH <b>June 11 1958</b>		5. SEX <b>Male</b>		
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-84</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Wales</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Bamford</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Griffith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 05 0949A</b>		17. INFORMANT <b>Lillian B. Bamford</b> Address <b>8026 Old. Phila. Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatosis</b> DUE TO (c) <b>Carcinoma Rectum</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2 yrs</b> <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial asthma</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1, 1958</b> to <b>June 11, 1958</b> that I last saw the deceased alive on <b>June 11, 1958</b> , and that death occurred at <b>5:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Balto 6 Md</b> DATE SIGNED <b>6/11/58</b>							
ACTUAL SIGNATURE <b>Wm Baumgardner</b> M.D.				PHYSICIAN'S NAME (Type) <b>George Baumgardner</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-14-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Taylor Ave. Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Blight Inc. 6009 Harford Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>6/20/58</b>		24b. REGISTRAR'S SIGNATURE <b>Q. L. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06465

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8245 EASTERN AVE.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u> d. STREET ADDRESS <u>18245 EASTERN AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>LOUISE M BARBOUR</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>JUNE 10 1958</u> Month Day Year									
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12/21/1885</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OHIO</u>				<b>11. BIRTHPLACE</b> (State or foreign country)				<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>MYER</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>ABOVE</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> <u>218-09-662A</u>				<b>17. INFORMANT</b> <u>HOWARD MYERS</u> Address <u>ABOVE</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>422.1</u> DUE TO <u>A-S-C-V- DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ca of Rectum</u>												INTERVAL BETWEEN ONSET AND DEATH _____	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <u>M. B. Davis</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>6/12/58</u>	
<b>EXAMINER'S NAME</b> (Type) <u>M. B. DAVIS</u>						<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>22b. DATE THEREOF</b> <u>6/12/58</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>oak lawn</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTO. MD.</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Connelly</u> <b>ADDRESS</b> <u>Essex 21, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>12 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF MEDICAL EXAMINER	
11. PLACE OF BIRTH		12. DATE OF BIRTH		13. PLACE OF DEATH		14. DATE OF DEATH		15. SIGNATURE OF MEDICAL EXAMINER	
16. PLACE OF BIRTH		17. DATE OF BIRTH		18. PLACE OF DEATH		19. DATE OF DEATH		20. SIGNATURE OF MEDICAL EXAMINER	
21. PLACE OF BIRTH		22. DATE OF BIRTH		23. PLACE OF DEATH		24. DATE OF DEATH		25. SIGNATURE OF MEDICAL EXAMINER	
26. PLACE OF BIRTH		27. DATE OF BIRTH		28. PLACE OF DEATH		29. DATE OF DEATH		30. SIGNATURE OF MEDICAL EXAMINER	
31. PLACE OF BIRTH		32. DATE OF BIRTH		33. PLACE OF DEATH		34. DATE OF DEATH		35. SIGNATURE OF MEDICAL EXAMINER	
36. PLACE OF BIRTH		37. DATE OF BIRTH		38. PLACE OF DEATH		39. DATE OF DEATH		40. SIGNATURE OF MEDICAL EXAMINER	
41. PLACE OF BIRTH		42. DATE OF BIRTH		43. PLACE OF DEATH		44. DATE OF DEATH		45. SIGNATURE OF MEDICAL EXAMINER	
46. PLACE OF BIRTH		47. DATE OF BIRTH		48. PLACE OF DEATH		49. DATE OF DEATH		50. SIGNATURE OF MEDICAL EXAMINER	
51. PLACE OF BIRTH		52. DATE OF BIRTH		53. PLACE OF DEATH		54. DATE OF DEATH		55. SIGNATURE OF MEDICAL EXAMINER	
56. PLACE OF BIRTH		57. DATE OF BIRTH		58. PLACE OF DEATH		59. DATE OF DEATH		60. SIGNATURE OF MEDICAL EXAMINER	
61. PLACE OF BIRTH		62. DATE OF BIRTH		63. PLACE OF DEATH		64. DATE OF DEATH		65. SIGNATURE OF MEDICAL EXAMINER	
66. PLACE OF BIRTH		67. DATE OF BIRTH		68. PLACE OF DEATH		69. DATE OF DEATH		70. SIGNATURE OF MEDICAL EXAMINER	
71. PLACE OF BIRTH		72. DATE OF BIRTH		73. PLACE OF DEATH		74. DATE OF DEATH		75. SIGNATURE OF MEDICAL EXAMINER	
76. PLACE OF BIRTH		77. DATE OF BIRTH		78. PLACE OF DEATH		79. DATE OF DEATH		80. SIGNATURE OF MEDICAL EXAMINER	
81. PLACE OF BIRTH		82. DATE OF BIRTH		83. PLACE OF DEATH		84. DATE OF DEATH		85. SIGNATURE OF MEDICAL EXAMINER	
86. PLACE OF BIRTH		87. DATE OF BIRTH		88. PLACE OF DEATH		89. DATE OF DEATH		90. SIGNATURE OF MEDICAL EXAMINER	
91. PLACE OF BIRTH		92. DATE OF BIRTH		93. PLACE OF DEATH		94. DATE OF DEATH		95. SIGNATURE OF MEDICAL EXAMINER	
96. PLACE OF BIRTH		97. DATE OF BIRTH		98. PLACE OF DEATH		99. DATE OF DEATH		100. SIGNATURE OF MEDICAL EXAMINER	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6490

## CERTIFICATE OF DEATH

06466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>36 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster (Rural)</b> <i>06X-2</i>	
f. STREET ADDRESS <b>RFD #6, Box 137</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>F.</b> Last <b>BARNES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1904</b>
9. AGE (In years last birthday) yrs. <b>54</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Revenue Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Danvers, Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John F. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Martha Taplin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>Peace Time</b>		16. SOCIAL SECURITY NO. <b>578-10-5835</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT LOWER LOBE</b> DUE TO <b>CARCINOMA, LEFT LUNG, RESECTED, METASTATIC TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>MEDIASTINUM</b> DUE TO (b) <b>MEDIASTINUM</b> (c)		INTERVAL BETWEEN ONSET OF DISEASE AND DEATH <b>10 DAYS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation - Pneumonectomy - November 2, 1954</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5, 1958</b> , to <b>June 10, 1958</b> , and that death occurred at <b>9:05 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles T. Fitch</i>		DATE SIGNED <b>6/10/58</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES T. FITCH, M.D.</b>		ADDRESS (Street, city or town, state) <b>M.D. VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-13-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook - Blight, Inc.</i>		24a. REC'D BY REGISTRAR <b>JUN 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <i>Wm Cook - Blight, Inc.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

DATE

TIME

PLACE

TIME

DATE OF DEATH

PLACE

TIME

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6491

Item 1 FilmG231 7-7-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

06467

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>				c. LENGTH OF STAY IN 1b <b>10 Mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>(Daughter's home)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELMER ROSS BAY</b>				4. DATE OF DEATH Month Day Year <b>JUNE 28, 1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 27, 1865</b>	9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRI.</b>		11. BIRTHPLACE (State or foreign country) <b>HARFORD Co., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>KENNEDY BAY</b>				14. MOTHER'S MAIDEN NAME <b>MARY ENFIELD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>MRS. WALTER WILHELM, DELTA, PA.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Cerebral vascular accident</b> DUE TO (b) <b>Atrial fibrillation</b> DUE TO (c) <b>Arteriosclerotic heart dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>± 5 d.</b> <b>6 y.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>— 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 27, 1957</b> to <b>6/28, 1958</b> that I last saw the deceased alive on <b>6/28, 1958</b> , and that death occurred at <b>445 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Christian S. Mass</b>				ADDRESS (Street, city or town, state) <b>11 E. Chase, Baltimore 2, Md.</b>			
PHYSICIAN'S NAME (Type) <b>CHRISTIAN S. MASS</b>				DATE SIGNED <b>9, Aug.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-1-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SLATE RIDGE</b>		22d. LOCATION (City, town, or county) (State) <b>DELTA, PENNA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harbison, Delta, Pa.</b>				24a. REC'D BY REGISTRAR <b>DATE JUL 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	



# CERTIFICATE OF DEATH

1931

EDWARD

CHILD

DATE

TIME

PLACE

10-1-31

AGE

SEX

RACE

10-1-31

CAUSE

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6492

## CERTIFICATE OF DEATH

06468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>21 Hrs. 19 M.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address; OR INSTITUTION) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>828 West 32nd Street</b>	
3. NAME OF DECEASED (Type or print) <b>(Served as (NMI) EARL F. BELL)</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1900</b>
9. AGE (In years last birthday) <b>58</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roller Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Biscuit Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Bell</b>		14. MOTHER'S MAIDEN NAME <b>Emma Burnhart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I 216-01-9066</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>COR PULMONALE</b> DUE TO <b>PULMONARY EMPHYSEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>527.1</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>1 YEAR</b> <b>6 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PNEUMONIA, LEFT LOWER LOBE * Duration 5 Days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>491X</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>AM</b>		20f. (City or town) (County) (State) <b>AM</b>	
21. I certify that I attended the deceased from <b>June 4-11:00</b> 19 <b>58</b> , to <b>June 6,</b> 19 <b>58</b> , and that death occurred at <b>8:19 AM</b> , from the causes and on the date stated above. and that death occurred at <b>8:19 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 6/5/58</b>			
ACTUAL SIGNATURE <b>Irving Freeman</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D. Chief, Medical Service</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 9, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Zion Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Zion Church, Baltimore Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Seitz Funeral Home, Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR <b>June 9 58</b>	24b. REGISTRAR'S SIGNATURE <b>W. S. Seitz</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10-1

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6493

CERTIFICATE OF DEATH

Reg. Dist. No. 06469

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>8 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>Box 32</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SIDNEY</b> Middle <b>A.</b> Last <b>BELL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>September 13, 1918</b>
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck-Driver, self empl.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce Hauling</b>	
11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Sidney P. Bell</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Horner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>234 67 9494</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN TUMOR</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Cerebral Arteriogram - 6/2/58 2. Left Sub-temporal decompression and removal of tissue for biopsy - 6/3/58.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 27</b> 19 <b>58</b> , to <b>June 4</b> 19 <b>58</b> , and that death occurred at <b>2:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/4/58</b> ACTUAL SIGNATURE <b>Joseph M. Miller</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>JOSEPH M. MILLER, M.D., Chief, Surgical Service, VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-6-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JUN 10 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

Baltimore, Md.

CERTIFICATE OF DEATH

1931

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

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DATE OF BIRTH

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EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6494

## CERTIFICATE OF DEATH

Reg. Dist. No. 06470

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Balto. Co.</b> 7324 Kirtley Rd.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>17324 Kirtley Road</b>	
3. NAME OF DECEASED (Type or print) <b>Evelyn M. Beyer</b>		4. DATE OF DEATH <b>June 22, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE STATUS <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>Jan. 7, 1923</b>
9. AGE (In years lost birth day) <b>35</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laboratory Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Romashoss &amp; Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Wilkinson</b>		14. MOTHER'S MAIDEN NAME <b>Mabel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>194-12-3500</b>	
17. INFORMANT <b>Lawrence Beyer</b>		Address <b>7324 Kirtley Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X cadaveria, general carcinoma stomach</b> DUE TO (b) <b>carcinoma of cervix uteri</b> DUE TO (c) <b>lying cause lost.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 mos.</b> <b>15 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work Not while at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 3, 1957</b> to <b>June 21, 1958</b> , that I last saw the deceased alive on <b>June 21, 1958</b> , and that death occurred at <b>6:45 p. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. C. Tobial</b>		DATE SIGNED <b>447 N. Kenwood Ave.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U.S. National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwig Sons, 2024 Orleans St.</b>		24a. REC'D BY REGISTRAR <b>JUN 25 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>2024 Orleans St.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

For this use

<p>1. Name of deceased: <b>John William</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>Jan 1, 1888</b></p>		<p>4. Age: <b>35</b></p>	
<p>5. Place of birth: <b>Massachusetts</b></p>		<p>6. Date of death: <b>June 12, 1923</b></p>	
<p>7. Cause of death: <b>Heart disease</b></p>		<p>8. Place of death: <b>Home</b></p>	
<p>9. Signature of physician: <b>John William</b></p>		<p>10. Signature of registrar: <b>John William</b></p>	
<p>11. Date of registration: <b>June 12, 1923</b></p>		<p>12. Place of registration: <b>Boston</b></p>	
<p>13. Name of informant: <b>John William</b></p>		<p>14. Address of informant: <b>123 Main St, Boston</b></p>	
<p>15. Name of informant: <b>John William</b></p>		<p>16. Address of informant: <b>123 Main St, Boston</b></p>	
<p>17. Name of informant: <b>John William</b></p>		<p>18. Address of informant: <b>123 Main St, Boston</b></p>	
<p>19. Name of informant: <b>John William</b></p>		<p>20. Address of informant: <b>123 Main St, Boston</b></p>	
<p>21. Name of informant: <b>John William</b></p>		<p>22. Address of informant: <b>123 Main St, Boston</b></p>	
<p>23. Name of informant: <b>John William</b></p>		<p>24. Address of informant: <b>123 Main St, Boston</b></p>	
<p>25. Name of informant: <b>John William</b></p>		<p>26. Address of informant: <b>123 Main St, Boston</b></p>	
<p>27. Name of informant: <b>John William</b></p>		<p>28. Address of informant: <b>123 Main St, Boston</b></p>	
<p>29. Name of informant: <b>John William</b></p>		<p>30. Address of informant: <b>123 Main St, Boston</b></p>	
<p>31. Name of informant: <b>John William</b></p>		<p>32. Address of informant: <b>123 Main St, Boston</b></p>	
<p>33. Name of informant: <b>John William</b></p>		<p>34. Address of informant: <b>123 Main St, Boston</b></p>	
<p>35. Name of informant: <b>John William</b></p>		<p>36. Address of informant: <b>123 Main St, Boston</b></p>	
<p>37. Name of informant: <b>John William</b></p>		<p>38. Address of informant: <b>123 Main St, Boston</b></p>	
<p>39. Name of informant: <b>John William</b></p>		<p>40. Address of informant: <b>123 Main St, Boston</b></p>	
<p>41. Name of informant: <b>John William</b></p>		<p>42. Address of informant: <b>123 Main St, Boston</b></p>	
<p>43. Name of informant: <b>John William</b></p>		<p>44. Address of informant: <b>123 Main St, Boston</b></p>	
<p>45. Name of informant: <b>John William</b></p>		<p>46. Address of informant: <b>123 Main St, Boston</b></p>	
<p>47. Name of informant: <b>John William</b></p>		<p>48. Address of informant: <b>123 Main St, Boston</b></p>	
<p>49. Name of informant: <b>John William</b></p>		<p>50. Address of informant: <b>123 Main St, Boston</b></p>	
<p>51. Name of informant: <b>John William</b></p>		<p>52. Address of informant: <b>123 Main St, Boston</b></p>	
<p>53. Name of informant: <b>John William</b></p>		<p>54. Address of informant: <b>123 Main St, Boston</b></p>	
<p>55. Name of informant: <b>John William</b></p>		<p>56. Address of informant: <b>123 Main St, Boston</b></p>	
<p>57. Name of informant: <b>John William</b></p>		<p>58. Address of informant: <b>123 Main St, Boston</b></p>	
<p>59. Name of informant: <b>John William</b></p>		<p>60. Address of informant: <b>123 Main St, Boston</b></p>	
<p>61. Name of informant: <b>John William</b></p>		<p>62. Address of informant: <b>123 Main St, Boston</b></p>	
<p>63. Name of informant: <b>John William</b></p>		<p>64. Address of informant: <b>123 Main St, Boston</b></p>	
<p>65. Name of informant: <b>John William</b></p>		<p>66. Address of informant: <b>123 Main St, Boston</b></p>	
<p>67. Name of informant: <b>John William</b></p>		<p>68. Address of informant: <b>123 Main St, Boston</b></p>	
<p>69. Name of informant: <b>John William</b></p>		<p>70. Address of informant: <b>123 Main St, Boston</b></p>	
<p>71. Name of informant: <b>John William</b></p>		<p>72. Address of informant: <b>123 Main St, Boston</b></p>	
<p>73. Name of informant: <b>John William</b></p>		<p>74. Address of informant: <b>123 Main St, Boston</b></p>	
<p>75. Name of informant: <b>John William</b></p>		<p>76. Address of informant: <b>123 Main St, Boston</b></p>	
<p>77. Name of informant: <b>John William</b></p>		<p>78. Address of informant: <b>123 Main St, Boston</b></p>	
<p>79. Name of informant: <b>John William</b></p>		<p>80. Address of informant: <b>123 Main St, Boston</b></p>	
<p>81. Name of informant: <b>John William</b></p>		<p>82. Address of informant: <b>123 Main St, Boston</b></p>	
<p>83. Name of informant: <b>John William</b></p>		<p>84. Address of informant: <b>123 Main St, Boston</b></p>	
<p>85. Name of informant: <b>John William</b></p>		<p>86. Address of informant: <b>123 Main St, Boston</b></p>	
<p>87. Name of informant: <b>John William</b></p>		<p>88. Address of informant: <b>123 Main St, Boston</b></p>	
<p>89. Name of informant: <b>John William</b></p>		<p>90. Address of informant: <b>123 Main St, Boston</b></p>	
<p>91. Name of informant: <b>John William</b></p>		<p>92. Address of informant: <b>123 Main St, Boston</b></p>	
<p>93. Name of informant: <b>John William</b></p>		<p>94. Address of informant: <b>123 Main St, Boston</b></p>	
<p>95. Name of informant: <b>John William</b></p>		<p>96. Address of informant: <b>123 Main St, Boston</b></p>	
<p>97. Name of informant: <b>John William</b></p>		<p>98. Address of informant: <b>123 Main St, Boston</b></p>	
<p>99. Name of informant: <b>John William</b></p>		<p>100. Address of informant: <b>123 Main St, Boston</b></p>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va</b> b. COUNTY <b>Mercer County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>6 HRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SRRING CROVE STATE HOS</b>		d. STREET ADDRESS <b>Pin oak W. Va</b>	
3. NAME OF DECEASED (Type or print) <b>HERBERT BIGGS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/16/1922</b>
9. AGE (In years last birthday) <b>36 yrs.</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b>	IF UNDER 24 HRS. Hours <b>12</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining Industry</b>	
11. BIRTHPLACE (State or foreign country) <b>Mercer County W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Thomas D. Biggs</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Lusk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>RECORDS OF Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial asthma</b> <b>322.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Delirium tremens</b> DUE TO (c) <b>Acute Chronic alcoholism</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. S. McKieffer</b>		DATE SIGNED <b>JUNE 29 1958</b>	
EXAMINER'S NAME (Type) <b>GEO. S. M KIEFFER</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Family Plot</b>	22b. DATE THEREOF <b>7/5/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mercer County W. Va</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mac Habb &amp; Son Inc</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 2 '58</b>	
ADDRESS <b>Bailey Funeral Home Princeton W. Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6496

## CERTIFICATE OF DEATH

Reg. Dist. No.

06472

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Railroad Ave</u>				d. STREET ADDRESS <u>Railroad Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Franklin</u> Last <u>Blizzard</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>June 22</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Blizzard</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Kemp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Carrie Poe-daughters name</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerotic cardiovascular disease</u> DUE TO (c) <u>10 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>3 June 1958</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.				ADDRESS (Street, city or town, state) <u>Cockeysville</u> DATE SIGNED <u>5 June 58</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>				<u>Cockeysville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Gilead</u>		22d. LOCATION (City, town, or county) (State) <u>Woodensburg, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brook</u>				ADDRESS <u>622 York Rd., Towson 4, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Walter Kemp</u>			



6497

## CERTIFICATE OF DEATH

06473

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO 7</u>				c. LENGTH OF STAY IN 1b <u>26 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOGWOOD ROAD.</u>				e. STREET ADDRESS <u>DOGWOOD ROAD</u>			
3. NAME OF DECEASED (Type or print) <u>SUSAN CATHERINE BOWERS</u>				4. DATE OF DEATH <u>JUNE 2 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 22-1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOMEKEEPING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSHUA MULLINIX</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-6926</u>		17. INFORMANT <u>MRS HENRY BECKER - Dogwood Rd -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT - 442x</u> DUE TO <u>HYPERTENSIVE C.V. DISEASE, c</u> DUE TO <u>RENAL INSUFFICIENCY -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 1 1958</u> , to <u>JUNE 2 1958</u> , that I last saw the deceased alive on <u>JUNE 2 1958</u> , and that death occurred at <u>3001 CLIFMAR RD - 7 -</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>THOMAS E. WHEELER</u> M.D. <u>6/2/58</u> PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>Randalltown 17d</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higginbotham</u> ADDRESS <u>ELLIOTT CITY, MD</u>				24a. REC'D BY REGISTRAR <u>DATE 6-5-58</u>		24b. REGISTRAR'S SIGNATURE <u>Ant. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1880</i></p>		<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. PLACE OF DEATH <i>Home</i></p>		<p>9. TIME OF DEATH <i>10:30 AM</i></p>		<p>10. DATE OF DEATH <i>Jan 20 1925</i></p>		<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. TIME OF DEATH <i>10:30 AM</i></p>	
<p>13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>14. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i></p>		<p>15. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i></p>		<p>16. NAME OF MINISTER <i>Rev. J. H. Smith</i></p>		<p>17. NAME OF CHURCH <i>St. Paul's Church</i></p>		<p>18. NAME OF CEMETERY <i>Greenwood Cemetery</i></p>	
<p>19. NAME OF DECEASED <i>John Doe</i></p>		<p>20. SEX <i>Male</i></p>		<p>21. AGE <i>45</i></p>		<p>22. DATE OF BIRTH <i>Jan 15 1880</i></p>		<p>23. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>24. OCCUPATION <i>Teacher</i></p>	
<p>25. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>26. PLACE OF DEATH <i>Home</i></p>		<p>27. TIME OF DEATH <i>10:30 AM</i></p>		<p>28. DATE OF DEATH <i>Jan 20 1925</i></p>		<p>29. PLACE OF DEATH <i>Home</i></p>		<p>30. TIME OF DEATH <i>10:30 AM</i></p>	
<p>31. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>32. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i></p>		<p>33. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i></p>		<p>34. NAME OF MINISTER <i>Rev. J. H. Smith</i></p>		<p>35. NAME OF CHURCH <i>St. Paul's Church</i></p>		<p>36. NAME OF CEMETERY <i>Greenwood Cemetery</i></p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6498

## CERTIFICATE OF DEATH

Reg. Dist. No. 06474

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1018 WAGNER Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>E. Gillet Boyce</u>		4. DATE OF DEATH <u>June 6 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9 1911</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>W. Graham Boyce</u>	
14. MOTHER'S MAIDEN NAME <u>Elise Gillet</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-24-0108</u>		17. INFORMANT <u>Ms E Gillet Boyce</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0</u> DUE TO <u>Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Pylonephritis</u> DUE TO (c) <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 28, 1958</u> to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>June 5, 1958</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Pearce</u> M.D.		ADDRESS (Street, city or town, state) <u>2105 N Charles St Baltimore 18 Md</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM F. PEARCE</u>		DATE SIGNED <u>4/6/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 9 1958</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Jenkins &amp; Sons Co</u> ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6499

## CERTIFICATE OF DEATH

06475

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>at home</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wayne Nursing Home-98 Smithwood Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2601 Oakley Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CORDELIA</b> Middle <b>MILDRED</b> Last <b>BULL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1872</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months <b>86</b> Days <b>25</b> Hours <b>19</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George W. Berry</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Delcher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Ralph H. Amrein - 2511 Oakley Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>900.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PNEUMONIA</b> (c) <b>FRACTURE OF HIP</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS.</b> <b>6.0 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>APPARENTLY TRIPPED &amp; FELL ON STEPS</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>MAY 1958</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Baltimore Co. MD.</b>	
21. I certify that I attended the deceased from <b>APRIL 1958</b> to <b>JUNE 25, 1958</b> , that I last saw the deceased alive on <b>JUNE 25, 1958</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Lickner</b>		DATE SIGNED <b>6-26-58</b>	
PHYSICIAN'S NAME (Type) <b>J. Lickner</b>		ADDRESS (Street, city or town, state) <b>614 Lombard St. Baltimore 21, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/28/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Lickner &amp; Sons - Radio 17</b>		24a. REC'D BY REGISTRAR <b>27 58</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>W. L. Beach</b>			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1955		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of birth		18. Sex		19. Age		20. Signature of informant	
Jane Doe		Wife		123 Main St		New York		NY		10001		1910		Female		35		[Signature]	
21. Name of funeral home		22. Address		23. City		24. State		25. Zip		26. Date of burial		27. Time of burial		28. Place of burial		29. Signature of funeral home		30. Signature of registrar	
ABC Funeral Home		456 Elm St		New York		NY		10001		1955		11:00 AM		Cemetery		[Signature]		[Signature]	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF VITAL STATISTICS, NEW YORK, NEW YORK, ON [DATE] 1955.

RECEIVED

1955

6500

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2901 Chenoak Ave.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2901 Chenoak Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Raymond Chenoweth</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John G. Chenoweth</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Fuller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-22-7523</u>	
17. INFORMANT <u>Mrs. Hazel Chenoweth</u>		Address <u>2901 Chenoak Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>162.1</u> DUE TO <u>Primary Lung Ca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to Brain</u> (c) <u>Bronchiectasis old</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>First detected in April 1955</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Oct 54</u> , 19 <u>54</u> , to <u>June 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u>		ADDRESS (Street, city or town, state) <u>9005 Harford Rd., Baltimore</u> DATE SIGNED <u>14, Md. 6/28/58</u>	
PHYSICIAN'S NAME (Type) <u>Frank T. Kasik, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-30-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Assault Fun'l Home Inc. 744 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1921

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1876		BALTIMORE		BALTIMORE		BALTIMORE		MD	
MARRIED		WIFE		NAME		AGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		COUNTY		STATE	
MARRIED		WIFE		MARY H. HARRIS		42		1900		BALTIMORE		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		TIME OF DEATH		HOUR	
HEART DISEASE		NATURAL		HOME		BALTIMORE		BALTIMORE		BALTIMORE		1921		10:00 AM		10:00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

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2005 HARRIS RD., BALTIMORE, MD 21206  
 TEL. 525-1234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6501

Baltimore County  
CERTIFICATE OF DEATH

Reg. Dist. 06477

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>city - zone 6</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>Baltimore</u>		<u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<u>My Hall Nursing Home</u>		<u>5409 Mayview - zone 6</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>RUTH</u> <u>Elizabeth</u> <u>Chlada</u>		Month Day Year <u>6</u> <u>21</u> <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/20/1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Telephone operator</u>		<u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Baltimore, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>George Benner</u>		<u>FANNIE Elizabeth Potee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<u>(If yes, give war or dates of service)</u>		<u>MR. Ambrose J. Chlada Stars</u>	
17. INFORMANT		Address	
<u>MR. Ambrose J. Chlada Stars</u>		<u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>uremia</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>General Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
<u>February 1958</u> to <u>June 21, 1958</u>		<u>6 P.M.</u> 1958, and that death occurred at <u>6:52</u> M, from the causes and on the date stated above.	
21. I certify that I attended the deceased from <u>February 1958</u> to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>6 P.M.</u> 1958, and that death occurred at <u>6:52</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <u>Samuel Stern, M.D.</u> M.D.		<u>Ridge Rd.</u> DATE SIGNED <u>6/21/58</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL STERN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>6-25-58</u>		<u>London Park</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>London Park</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Leonard J. Kuck</u>		<u>1305 Hayford</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUN 25 '58</u>		<u>W. J. Kuck</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6502

CERTIFICATE OF DEATH

Reg. Dist. No. 06478

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7811 Telmont</i>		d. STREET ADDRESS <i>7811 Telmont</i>	
3. NAME OF DECEASED (Type or print) <i>Christian K. Claypoole</i>		4. DATE OF DEATH <i>June 28 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-21-1898</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Colonel Army</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <i>Balto Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harry Claypoole</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Smuold</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>213-09-0880</i>	
17. INFORMANT <i>Mrs. Martha A. Claypoole</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Adams Stokes Synd.</i> DUE TO <i>Old Coronary Thrombosis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 10, 1955</i> , to <i>Present</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>June 10, 1958</i> , and that death occurred at <i>9:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik</i>		DATE SIGNED <i>6/28/58</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T. KASIK JR</i>		<i>BAITO 14 Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>7-2-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lemond Gluck</i>		ADDRESS <i>5305 Harford</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>JUL 1 '58</i>			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6503

CERTIFICATE OF DEATH

06479

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>None</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <u>Sidney</u> Middle <u>A.</u> Last <u>Coon</u>		4. DATE OF DEATH		Month <u>6</u> Day <u>10</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/77</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Hawleyton, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Peter J. S. Coon</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Bertha Gage</u>		Address <u>Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>  </u> p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>58</u> , to <u>June 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>58</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irving R Beck</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>901 Fuselage av. Baltimore 20 Md</u>					
PHYSICIAN'S NAME (Type) <u>IRVING R. BECK, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chenango Valley Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Binghamton, N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc.</u>				ADDRESS <u>1217 St. Paul St., Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 12 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Albert Smith</u>			



6504

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balti.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Aintree Road</b>		d. STREET ADDRESS <b>8 Aintree Road #4</b>	
3. NAME OF DECEASED (Type or print) First <b>A. J.</b> Middle <b>WINIFRED</b> Last <b>CROMWELL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1886</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John McPhail</b>		14. MOTHER'S MAIDEN NAME <b>Anne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>Mr. Robert Cromwell-6455 Blenheim Road #12</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1946</b> , to <b>19 June 1958</b> , that I last saw the deceased alive on <b>19 June 1958</b> , and that death occurred at <b>9 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Reier</b>		ADDRESS (Street, city or town, state) <b>6701 York Rd Baltimore Md</b> DATE SIGNED <b>20 June 58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/21/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker</b> ADDRESS <b>Balto-17, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06481

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>56 Days</b>		d. STREET ADDRESS <b>801 E. Lexington St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fort Howard Hospital Vet. Adm.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RICHARD D. CROUCH</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 12, 1909</b>
9. AGE (In years last birthday) <b>49 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter Building</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Crouch</b>		14. MOTHER'S MAIDEN NAME <b>Lula Griffin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>243 -10- 9361</b>	
17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition due to Head Injury</b> <b>983X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pushed down flight of stairs</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>3/21/58</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Baltimore Maryland</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>7/1/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7/1/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Farmers Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Farmers North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook - Blight, Inc.</b>		ADDRESS <b>6009 Harford Road</b>	
24a. REC'D BY REGISTRAR <b>JUL 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		APR 4 1968		MEMPHIS, TENN.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
MEMPHIS, TENN.		ATTORNEY		HEART DISEASE		NATURAL		MEMPHIS, TENN.		APR 4 1968	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF SIGNATURE	
APR 4 1968		10:00 AM		MEMPHIS, TENN.		JAMES EARL RAY		MEDICAL EXAMINER		APR 4 1968	
DATE OF REPORT		TIME OF REPORT		PLACE OF REPORT		SIGNATURE OF REPORTER		TITLE OF REPORTER		DATE OF SIGNATURE	
APR 4 1968		10:00 AM		MEMPHIS, TENN.		JAMES EARL RAY		MEDICAL EXAMINER		APR 4 1968	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06482

Reg. Dist. No.

6506

1. PLACE OF DEATH a. COUNTY <b>BALTO. Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Graceland Park</b>		c. LENGTH OF STAY IN 1b <b>40 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRACELAND PARK</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>603 WILSON AVE</b>				d. STREET ADDRESS <b>1603 WILSON AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELI</b> First Middle Last <b>CUTAN</b>				4. DATE OF DEATH Month <b>6</b> Day <b>2</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1893</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIP FITTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP YARD</b>		11. BIRTHPLACE (State or foreign country) <b>ROMANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES CUTAN</b>				14. MOTHER'S MAIDEN NAME <b>MARY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>25-01-3211</b>		17. INFORMANT <b>JOHN CUTAN</b> Address <b>603 WILSON AVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Artery Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of Liver</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. S. Fialkowski</b>				ADDRESS <b>2007 Eastern Ave</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6465

## CERTIFICATE OF DEATH

Reg. Dist. No.

06483

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>40 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>56 SHIPWAY</u>				d. STREET ADDRESS <u>56 SHIPWAY</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>DAIL</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>URIAH A. WILLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. ADAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>JACK DAIL JR.</u> Address <u>15 TOWNSHIP RD DUNDALK</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic hypertensive cardiovascular disease</u> DUE TO <u>disease</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>31 May</u> , 19 <u>58</u> , to <u>6 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 June</u> , 19 <u>58</u> , and that death occurred at <u>1 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6 June 1958</u>							
ACTUAL SIGNATURE <u>W. E. Baermann</u> M.D.		PHYSICIAN'S NAME (Type) <u>W. E. BAERMANN, M.D.</u> <u>33 Dundalk Avenue, Dundalk 22, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Brallegne</u> <u>per E. M. Duffy</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Baermann</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06484**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Hereford</u> c. LENGTH OF STAY IN 1b <u>0</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Rd.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u> <u>48X-3</u> d. STREET ADDRESS <u>1226 Second Ave N.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>William Henry Daniels</u> First Middle Last		<b>4. DATE OF DEATH</b> Month <u>JUNE</u> Day <u>28</u> Year <u>1958</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>B</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan 3, 1905</u>
<b>9. AGE</b> (In years last birthday) <u>53</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Transportation</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>MAKELAND, G.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Wm H. Daniels</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Fannie Serron</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>2</u>		<b>16. SOCIAL SECURITY NO.</b> <u>255-223383</u>	
<b>17. INFORMANT</b> <u>Mr. W. H. Daniels, 1226 2nd Ave N, St. Petersburg Fla.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ENTIRE body charred by fire</u> <u>822X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH?</b> <input checked="" type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Truck which he was driving overturned &amp; caught on fire. He burned with it.</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>3:30</u> p.m. <u>6/28</u> 19 <u>58</u>		<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Route 111</u>		<b>20f. (City or town) (County) (State)</b> <u>Hereford Balto, Md.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>A. M. France</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <u>A. M. FRANCE</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>6/28/58</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>22b. DATE THEREOF</b> <u>July 2, 1958</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Petersburg, Fla.</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>St. Petersburg, Fla.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Jacob Hartman, New Freedom, Pa.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUL 2 '58</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Al. Leach</u>			

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10 STATE  
HOSPITAL DIST

NAME OF DECEASED  
SEX

DATE OF DEATH

LOCAL RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION  
SCHOOL

PROFESSION - OCCUPATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6477

## CERTIFICATE OF DEATH

06485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b <b>51</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1319 Poplar Ave.</b>		d. STREET ADDRESS <b>1319 Poplar Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Davis</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> , Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2-1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Waring</b>		14. MOTHER'S MAIDEN NAME <b>Mary Martin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Edward J. Davis</b>		Address <b>1319 Poplar Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.1 DUE TO <b>recurrent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> DUE TO <b>General Arteriosclerosis</b> (c) <b>55 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b> <b>1 yr</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 16, 1958</b> to <b>June 16, 1958</b> , that I last saw the deceased alive on <b>June 16, 1958</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.		ADDRESS (Street, city or town, state) <b>516 09 Main St</b> DATE SIGNED <b>6/17/58</b>	
PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>		<b>Elphredge 27th</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-19-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Measow Ridge Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUN 18 1958</b>		24b. REGISTRAR'S SIGNATURE <b>One</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6508

## CERTIFICATE OF DEATH

064886

Reg. Dist. No. 32

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore County</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u> <u>11 mo.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side, Md</u> <u>02X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>Steamboat Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Everett</u> Last <u>Dement</u>				<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>8</u> Year <u>1958</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/24/1916</u>	
<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>6</u> Days <u>8</u> Hours <u>19</u> Min.		<b>IF UNDER 24 HRS.</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Manager-Store</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Grocery</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>James E. Dement</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah V. Jenkins</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>yes</u> <u>World War I</u>				<b>16. SOCIAL SECURITY NO.</b> <u>577-05-1079</u>		<b>17. INFORMANT</b> <u>Hospital Records, Mt. Wilson State Hospital</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>3/16</u> , 19 <u>58</u> , to <u>6/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/8/58</u> (19 <u>58</u> ), and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
<b>ACTUAL SIGNATURE</b> <u>William Newcomer</u> M.D.				<b>PHYSICIAN'S NAME</b> (Type) <u>William Newcomer, M.D.</u> <u>Superintendent</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b>		<b>22d. LOCATION</b> (City, town, or county) (State)	
<u>6-12-58</u>		<u>Fort Lincoln</u>		<u>Calmar Manor Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b>	
<u>James Lee Jones - 4141 W. Main St. Wash DC</u>				<u>JUN 11 '58</u>		<u>Arthur Smith</u>	



# CERTIFICATE OF DEATH

1902

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

<p>NAME OF DECEASED <i>James F. Brown</i></p>	
<p>AGE <i>35</i></p>	
<p>SEX <i>Male</i></p>	
<p>DATE OF DEATH <i>Jan 15 1902</i></p>	
<p>PLACE OF DEATH <i>Home</i></p>	
<p>Cause of Death <i>Heart Disease</i></p>	
<p>Signature of Physician <i>[Signature]</i></p>	
<p>Signature of Registrar <i>[Signature]</i></p>	
<p>Official Seal <i>[Seal]</i></p>	

1

6509

## CERTIFICATE OF DEATH

Reg. Dist. 06487

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>52</u> <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bidgeway Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SADIE</u> Middle <u>VIRGINIA</u> Last <u>DEMPSEY</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1875</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Austin Dempsey</u>				14. MOTHER'S MAIDEN NAME <u>Elexina Valentine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Edna Male - 401 Gralan Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO <u>Broncho-Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerotic Heart Disease</u> (c) <u>Generalized Arterio-Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>6 days</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-Sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov 4, 1953</u> to <u>June 3, 1958</u> , that I last saw the deceased alive on <u>June 2, 1958</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u>				DATE SIGNED <u>4-10-58</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>				ADDRESS (Street, city or town, state) <u>4106 Liberty Hts. Balt. Md. 6-4-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Wickner &amp; Sons - Balt.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Wickner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARIYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 10

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6466 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>53 Dundalk (22)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>58 Township Road</b>		d. STREET ADDRESS <b>58 Township Road</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Fred</b> Last <b>Denny</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> , Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1903</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boilermaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Hobough</b>	
14. MOTHER'S MAIDEN NAME <b>Nellie Denny</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes WWII</b>	
16. SOCIAL SECURITY NO. <b>216-10-3189</b>		17. INFORMANT <b>Mrs. Alma Denny same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/30/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Bradley</b>		24a. REC'D BY REGISTRAR <b>Dundalk 22 Maryland</b>	
		24b. REGISTRAR'S SIGNATURE <b>Al. Branch</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6510

## CERTIFICATE OF DEATH

Reg. Dist. No.

06489

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>30 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>245 Gralan Rd.</b>		d. STREET ADDRESS <b>245 Gralan Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Jensine</b> Middle <b>B.</b> Last <b>Dew</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Norway</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bertelsen</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Earl W. Dew (Son)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7.6</b> , 19 <b>50</b> , to <b>6.18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6.18</b> , 19 <b>58</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George E. Urban</b>		M.D. <b>805 Frederick Ave 28 Md</b>	
PHYSICIAN'S NAME (Type) <b>George E. URBAN</b>		DATE SIGNED <b>6.19.58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 21/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 20 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Oneh...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

Use Back for

PLACE OF DEATH Baltimore		COUNTY Baltimore	
CITY Baltimore		ZIP CODE 21201	
DECEASED John Doe		DATE OF BIRTH Jan 1, 1900	
SEX Male		RACE White	
OCCUPATION Teacher		MARITAL STATUS Married	
PLACE OF BIRTH Baltimore, Md		DATE OF DEATH Jan 1, 1950	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		SIGNATURE OF DECEASED John Doe	
SIGNATURE OF WITNESS John Doe		SIGNATURE OF PHYSICIAN John Doe	
SIGNATURE OF CLERK John Doe		SIGNATURE OF REGISTRAR John Doe	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6512

## CERTIFICATE OF DEATH

06491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>		d. STREET ADDRESS <u>7309 Prince Georges Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jeffery</u> Middle <u>Young</u> Last <u>Dubel</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1958</u>
9. AGE (In years last birthday) yrs. <u>16</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Dubel</u>		14. MOTHER'S MAIDEN NAME <u>Helen Miles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Robert Dubel</u>		Address <u>Pikesville 8, Md.</u> <u>7309 Prince Georges Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Heart Disease</u> (c) <u>probably Transposition of Blood Vessels</u>		INTERVAL BETWEEN ONSET OF DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date of nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 23, 1958</u> to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irving Kramer</u> M.D.		ADDRESS (Street, city or town, state) <u>700 Reisterstown Rd Pikesville</u> DATE SIGNED <u>June 11 '58</u>	
PHYSICIAN'S NAME (Type) <u>Irving Kramer M.D.</u>		700 Reisterstown Rd. Pikesville 8, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 9, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Quaker Burying Ground</u>	22d. LOCATION (City, town, or county) (State) <u>Galesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell Pikesville</u>		ADDRESS <u>Pikesville</u>	
24a. REC'D BY REGISTRAR <u>W. H. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6513

## CERTIFICATE OF DEATH

06492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3 VOI-4</b>	
f. STREET ADDRESS <b>4126 PARKSIDE DR.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEO</b> Middle <b>R.</b> Last <b>DUNN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James E. Dunn</b>		14. MOTHER'S MAIDEN NAME <b>Mary McCarron</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331x PULMONARY EDEMA</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UNKNOWN CAUSE</b> DUE TO (c) <b>CEREBRAL VASCULAR ACCIDENT</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs.</b> <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 13, 1958</b> , to <b>June 15, 1958</b> , and that death occurred at <b>5:10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Hunter Wilson</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>E. HUNTER WILSON, M.D.</b>		DATE SIGNED <b>6/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>JUNE 18-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dippel Brothers, 7110 Belair Rd., Balto. 6, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 17 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Overman</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6514

## CERTIFICATE OF DEATH

06493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Zone #7</b>				c. LENGTH OF STAY IN 1b <b>Zone #7</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1200 Ingleside Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>J.</b> Last <b>DUNNOCK</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1884</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter (rtd) self emp.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mr. Charles W. Dunnock - 1200 Ingleside Ave. 7</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 11, 1948</b> to <b>June 30, 1958</b> , that I last saw the deceased alive on <b>June 28, 1958</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4111 Liberty Heights Rd. Balt., Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Albert Shochat</b>		M.D. <b>4111 Liberty Heights Rd. Balt., Md.</b>					
PHYSICIAN'S NAME (Type) <b>Dr. H. J. Shochat M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Vickner &amp; Sons - Balt. 172</b>				24a. REC'D BY REGISTRAR <b>DATE JUL 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Vickner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6467

## CERTIFICATE OF DEATH

Reg. Dist. No.

06494

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write, RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>12 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3202 MCSHANEWAY</u>		d. STREET ADDRESS <u>3202 MCSHANEWAY</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACOB EUGENE EAGLE</u>		4. DATE OF DEATH Month Day Year <u>6/29/58</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 20, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CERAMIC</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JACOB EAGLE</u>		14. MOTHER'S MAIDEN NAME <u>MARY MC DONALD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>167-10-84</u>	
17. INFORMANT <u>JUNIA O'BRIEN EAGLE</u>		Address <u>- SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lungs.</u> DUE TO (b) <u>Generalized carcinoma due to metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-21</u> , 19 <u>58</u> , to <u>6-29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-29</u> , 19 <u>58</u> , and that death occurred at <u>11:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7001 MORNINGTON RD</u> DATE SIGNED <u>6/30/58</u> ACTUAL SIGNATURE <u>Eugene F Newy</u> PHYSICIAN'S NAME (Type) <u>EUGENE NEWY, MD</u> <u>7001 MORNINGTON - DUNDALK, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley, Dundalk, Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 2 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Reed Smith</u>

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

11

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6515

## CERTIFICATE OF DEATH

Reg. Dist. No.

06495

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>115 Slade Ave</u>				d. STREET ADDRESS <u>115 Slade Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARtha JANE Eaton</u>				4. DATE OF DEATH Month Day Year <u>June 3 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 10, 1874</u>		9. AGE (In years last birthday) yrs. <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Stuller</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Cornell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Joshua Eaton, 7020 Alden Rd, Pikesville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>few years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>3 June 1958</u> , that I last saw the deceased alive on <u>24 May 1958</u> , and that death occurred at <u>330 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H. Royse</u>				ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd</u>			
PHYSICIAN'S NAME (Type) <u>PAUL H. ROYSE MD</u>				DATE SIGNED <u>3 June 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06496

6516

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5415 Old Frederick Road</b>				d. STREET ADDRESS <b>5415 Old Frederick Road #29</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>C.</b> Last <b>EITEMILLER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 23, 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Christian G. Gruetzer</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Linck</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. C. Albert Eitemiller-7337 Windsor Mill Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>422.2</b> DUE TO (c) <b>422.2</b> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 5, 1958</b> to <b>June 16, 1958</b> that I last saw the deceased alive on <b>June 16, 1958</b> and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. J. Mendelis</b>				ADDRESS (Street, city or town, state) <b>651 N. Beutalou</b>			
PHYSICIAN'S NAME (Type) <b>C. J. Mendelis</b>				DATE SIGNED <b>6/16/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/19/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckner</b>				ADDRESS <b>Balto - 17 Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 17 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Out...</b>							



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page No. 18

NAME OF DECEASED

SEX

AGE

DATE

PLACE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

AGE

DATE

PLACE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06497

6517

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3522 Wild Cherry Road,</b>		d. STREET ADDRESS <b>3522 Wild Cherry Road (Balto 7)</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Warren</b> Last <b>Emmart</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>March 19, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(Retired) Farmer Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Rockdale</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Emmart</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Timanus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Elizabeth M. Emmart</b>		Address <b>3522 Wild Cherry Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA, RECTUM - C</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTASIS TO LIVER =</b> DUE TO (c) <b>2 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 1, 1954</b> , to <b>JUNE 16, 1958</b> , that I last saw the deceased alive on <b>JUNE 16, 1958</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas E. Wheeler</b> M.D. <b>3601 Chynar Rd</b>		ADDRESS (Street, city or town, state) <b>BALTO -</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS E. WHEELER</b>		DATE SIGNED <b>6/17/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 18, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Road, Randallstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 23 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. K. Smith</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6518

## CERTIFICATE OF DEATH

Reg. Dist. No. **CG498**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bird River</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 53</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 244 Ebenezer Rd.</b>				d. STREET ADDRESS <b>Box 244 Ebenezer Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>A.</b> Last <b>Eurice</b>				4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-4-1897</b>		9. AGE (In years last birthday) yrs. <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Joseph Eurice</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Winkler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-14-9964</b>		17. INFORMANT Address <b>Mrs. Theresa E. Eurice Box 244 Ebenezer Rd.</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Cancer - 153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary Carcinoma of Cecum</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-18</b> , 19 <b>58</b> , to <b>6-21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-21</b> , 19 <b>58</b> , and that death occurred at <b>10:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5402 Belair Rd. Balto. Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Michael J. Grossfeld</b>		M.D. <b>5402 Belair Rd. Balto. Md.</b>					
PHYSICIAN'S NAME (Type) <b>Michael J. Grossfeld MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-25-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Horne Inc. 7401 Belair Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6519 Item 7 FilmG230 6-18-58 et  
**CERTIFICATE OF DEATH**

06499

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Monkton</u>				c. LENGTH OF STAY IN 1b <u>5 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>J.M. Pearce Road</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton Rural</u>			
f. STREET ADDRESS <u>J.M. Pearce Rd.</u>				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Williams</u> Middle <u>M</u> Last <u>Evans</u>				4. DATE OF DEATH <u>June</u> Month <u>9</u> Day <u>1958</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 Oct - 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Evans Air Products</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gases</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George W Evans</u>				14. MOTHER'S MAIDEN NAME <u>Ann Cowan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>068-26-9976</u>		17. INFORMANT <u>Sister Pearce</u> Address <u>Monkton Md - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1956</u> to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>58</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.				ADDRESS (Street, city or town, state) <u>Cockeysville</u> DATE SIGNED <u>9 June 1958</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>				SIGNATURE <u>Mary Carol</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u> ADDRESS <u>622 York Rd., Towson 4, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. 18



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6520

## CERTIFICATE OF DEATH

06500

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6437 Kriel Street</b>		d. STREET ADDRESS <b>6437 Kriel Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dominic Fava</b> First Middle Last		4. DATE OF DEATH <b>June 10, 19 58</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12/13/1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fava Prod.</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Fava</b>		14. MOTHER'S MAIDEN NAME <b>Johanna M. Garbo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214.03.1991</b>	
17. INFORMANT <b>Mrs. Sarah Fava</b>		Address <b>6437 Kriel St. (7)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatous</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>57</b> , to <b>June</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>58</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Thos T. Abbott</b>		M.D. <b>4509 Liberty Heights Ave</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>6-11-58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/13/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd. 7</b>	
24a. REC'D BY REGISTRAR <b>JUN 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Abbott</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1875		New York City	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		2 weeks		10:30 AM	
Occupation		Education		Marital Status		Religion		Usual Residence	
Teacher		High School		Married		Roman Catholic		123 Main St, Baltimore	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Place of Death		Manner of Death		Cause of Death		Time of Death	
Jan 15, 1920		Home		Natural		Heart Disease		10:30 AM	
County		City		State		Country		District	
Baltimore		Baltimore		Maryland		United States		North	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6521

## CERTIFICATE OF DEATH

Reg. Dist. No.

06501

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton 4</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Ruxton 4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1500 Carrollton Avenue</b>				e. STREET ADDRESS <b>1500 Carrollton Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARTHA ELIZABETH FISHPAW</b>				4. DATE OF DEATH Month Day Year <b>June 2, 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>March 21, 1861</b>	9. AGE (In years last birthday) <b>97</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Henry Leaf</b>				14. MOTHER'S MAIDEN NAME <b>Mary Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. H.W. Shipley, Ruxton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial Failure</b> DUE TO (c) <b>arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>1 yr.</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cockeysville, Md.</b>				20g. (County) <b>Lutherville, Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>57</b> , to <b>June 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 1</b> , 19 <b>58</b> , and that death occurred at <b>6:30</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Lutherville, Md.</b> DATE SIGNED <b>6/3/58</b> ACTUAL SIGNATURE <b>George T. Gilmore</b> M.D. <b>Lutherville, Md.</b> PHYSICIAN'S NAME (Type) <b>G. T. GILMORE</b> <b>LUTHERVILLE, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 4, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jessops Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		DATE OF DEATH	
JAMES EARL RAY		APR 24 1928		APR 4 1968	
PLACE OF BIRTH		CITY OF BIRTH		CITY OF DEATH	
MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
ATTORNEY AT LAW		HEART DISEASE		NATURAL	
EDUCATION		DURATION OF ILLNESS		PLACE OF DEATH	
HIGH SCHOOL		SEVERAL MONTHS		HOME	
RELIGION		SEX		RACE	
METHODIST		MALE		WHITE	
MARRIAGE		EDUCATION		OCCUPATION	
MARRIED		HIGH SCHOOL		ATTORNEY AT LAW	
DATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
APR 1950		APR 4 1968		HOME	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED  
APR 10 1968  
BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06502

6478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4209 Washington Blvd.</b>		d. STREET ADDRESS <b>4209 Washington Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Cecil Warren Foer</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 24, 1907</b>
9. AGE (In years lost birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Am. Const. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Everette, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Charles G. Foer</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Householder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>173-14-4768</b>	
17. INFORMANT <b>LaDonna G. Foer</b>		Address <b>4209 Washington Blvd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>6 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Stomach &amp; Liver</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1952</b> to <b>June 8, 1958</b> , that I last saw the deceased alive on <b>June 6, 1958</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. Bradley Laugharty</b>		ADDRESS (Street, city or town, state) <b>1264 Francis Ave</b>	
PHYSICIAN'S NAME (Type) <b>A. Bradley Laugharty</b>		DATE SIGNED <b>6-8-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Everette Pa.</b>		22d. LOCATION (City, town, or county) (State) <b>Everett, Penn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	







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**MEDICAL CERTIFICATION**

2

VS A15ME  
BM 2/57

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 10 1918  
BALTIMORE

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. OCCUPATION: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. DATE OF BIRTH: [illegible]  
7. PLACE OF DEATH: [illegible]  
8. CAUSE OF DEATH: [illegible]  
9. MANNER OF DEATH: [illegible]  
10. SIGNATURE OF MEDICAL EXAMINER: [illegible]  
11. DATE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6479

## CERTIFICATE OF DEATH

Reg. Dist. No.

06504

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.2em;">Baltimore</span></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Halethorpe</span>		c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">31 yrs.</span>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="font-size: 1.2em;">1248 Elm Rd.</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">51 Halethorpe</span>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">Mamie Elizabeth Fritz</span>		<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">June</span> Day <span style="font-size: 1.2em;">7</span> Year <span style="font-size: 1.2em;">1958</span>	
5. SEX <span style="font-size: 1.2em;">Female</span>	6. COLOR OR RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">2/17/95</span>
9. AGE (In years last birthday) <span style="font-size: 1.2em;">63</span> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">House work</span>		10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Own Home</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <span style="font-size: 1.2em;">Chester Heck</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <span style="font-size: 1.2em;">John W. Fritz</span>		Address <span style="font-size: 1.2em;">1248 Elm Rd.</span>	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Coronary Occlusion</span> DUE TO (b) <span style="font-size: 1.5em;">Hypertensive arteriosclerotic Heart Disease and</span> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">10 min</span>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <span style="font-size: 1.2em;">Aug 1</span> , 19 <span style="font-size: 1.2em;">52</span> , to <span style="font-size: 1.2em;">June 7</span> , 19 <span style="font-size: 1.2em;">58</span> , that I last saw the deceased alive on <span style="font-size: 1.2em;">June 6</span> , 19 <span style="font-size: 1.2em;">58</span> , and that death occurred at <span style="font-size: 1.2em;">5:45 PM</span> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <span style="font-size: 1.2em;">A. Bradley Daugharthy</span>	ADDRESS (Street, city or town, state) <span style="font-size: 1.2em;">1264 Francis Ave Baltimore 27</span>
PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">A. Bradley Daugharthy, M.D.</span>	DATE SIGNED <span style="font-size: 1.2em;">6-8-58</span>

22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	22b. DATE THEREOF <span style="font-size: 1.2em;">6-10-58</span>	22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Baltimore National</span>	22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em;">Joseph J. Ambrose Jr.</span>		ADDRESS <span style="font-size: 1.2em;">1328 Sulphur Spring Rd. Baltimore 27, Md.</span>	
24a. REC'D BY REGISTRAR <span style="font-size: 1.2em;">JUN 10 '58</span>		24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6522

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonville</b>				c. LENGTH OF STAY IN TB <b>6 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forrest Haven Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>B.</b> Last <b>Fryfogle</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29th</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1866</b>		9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Practical Nursing</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md</b>	
13. FATHER'S NAME <b>Robert N. Waller</b>				14. MOTHER'S MAIDEN NAME <b>Jane Tase</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Olive Barnett</b> Address <b>3632 Marriott Lane Zone 7</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO SCLEROTIC CHANGES</b> DUE TO (c) <b>VASCULAR DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/27</b> , 19 <b>58</b> , to <b>6/29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/29</b> , 19 <b>58</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5500 EDMONSON AVE</b> DATE SIGNED <b>JOHN H. SHAW MD</b>							
ACTUAL SIGNATURE <b>John H. Shaw</b> M.D. <b>5500 EDMONSON AVE</b>							
PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW MD</b> <b>DR. J. H. SHAW</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 2, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Living Byers</b>				ADDRESS <b>8728 Liberty Road, Randallstown</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 8 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1998

**CERTIFICATE OF DEATH**

Reg. Dist. No. 32

6523

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>109 ALDERSHOT ROAD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES FRANKLIN GALLION, JR.</b>		4. DATE OF DEATH Month Day Year <b>6 22 1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-19-04</b>
9. AGE (In years last birthday) yrs. <b>54</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELEVATOR OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELEVATOR OPERATOR HOTEL</b>	
11. BIRTHPLACE (State or foreign country) <b>STATE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH GALLION</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE SALE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212 09 8545</b>	
17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-25-1956</b> , to <b>6-12-1958</b> , that I last saw the deceased alive on <b>6-22-1958</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>6-22-58</b> ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Superintendent</b> PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 25/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry A. Witzke, JR.</b>		24a. REC'D BY REGISTRAR <b>DATE 2 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Edmondson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN W. WILSON</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>1900</u></p>	
<p>5. Place of birth: <u>Alabama</u></p>		<p>6. Date of death: <u>1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of filing: <u>1945</u></p>		<p>12. File number: <u>1000</u></p>	

6524

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN lb <b>26 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Sparrows Point</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sparrows Point Hospital DISPENSARY</b>				d. STREET ADDRESS <b>911 "F" Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>RUFF</b> Last <b>GIBSON, SR</b>				4. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 16, 1906</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH GIBSON</b>				14. MOTHER'S MAIDEN NAME <b>LYLA HENRY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>713-07-7175</b>		17. INFORMANT <b>EVELYN R. GIBSON, JR.</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C-V-Disease</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M. B. Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-23-58</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OFK LAWN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. Co., md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Burke Bradley, Husbands, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 26 '58</b>		24. REGISTRAR'S SIGNATURE <b>W. Search</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# 1 X M 50 I 2 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

6525

## CERTIFICATE OF DEATH

Reg. Dist. No.

06508

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>22 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>(MAY)</b> Last <b>GONSHOR</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 29 1888</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MILL</b>		11. BIRTHPLACE (State or foreign country) <b>WARSAW POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOSEPH GONSHOR</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>213-07-5333</b>			
17. INFORMANT <b>CLIN REC VET ADM HOSP FT HOWARD MARYLAND</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LARYNX WITH EXTENSIVE METASTASIS TO THE NECK ORGANS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>161X</b> (c) <b>UNKNOWN</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b> 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>MAY 10</b> 19 <b>58</b> , to <b>JUNE 1</b> 19 <b>58</b> , and that death occurred at <b>4:10</b> a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH FORT HOWARD MARYLAND</b> DATE SIGNED <b>6-1-58</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH FORT HOWARD MARYLAND</b> <b>6-1-58</b> PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN</b> M D <b>VAH FORT HOWARD MARYLAND</b> <b>6-1-58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>6/4/58</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART OF MARY</b>				22d. LOCATION (City, town, or county) (State) <b>BALTIMORE 22 MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>Walter Brooks Bradley</b>							

WALTER BROOKS BRADLEY INC 700 WILLOW SPRING RD BALTIMORE 22 MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6526

## CERTIFICATE OF DEATH

06509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 Westover Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John C. Grannan</u> First Middle Last <u>St.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene E. Grannan</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Beal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2-14-16-5640</u>	
17. INFORMANT <u>Mrs. Amy Grannan</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V.D.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 June, 1958</u> , to <u>POA</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>POA</u> , 19 <u>58</u> , and that death occurred at <u>3:15 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles P. Williams</u> M.D. <u>1632 Penitentiary Pl</u>		ADDRESS (Street, city or town, state) <u>Pikesville 8, Md.</u> DATE SIGNED <u>Jun-26-58</u>	
PHYSICIAN'S NAME (Type) <u>Charles A. Williams, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/30/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Greenwith Amace</u> ADDRESS <u>4600 Liberty Heights Ave. - 7</u>		24a. REC'D BY REGISTRAR <u>JUN 30 '58</u> DATE <u>6/30/58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Sp I called Dr. Paul Hooper, Pikesville, and he has been under regular care for 5 years off

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 15

6527

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>XXX Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Approx. 2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		d. STREET ADDRESS <b>928 Gorsuch Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret Ann</b> Middle <b>Martin</b> Last <b>Griffith</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Martin</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Admission Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Renal</b> (c) <b>Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 20, 1958</b> to <b>June 23, 1958</b> , that I last saw the deceased alive on <b>June 20, 1958</b> , and that death occurred at <b>8:17 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F. Dorrnell</b> M.D.		ADDRESS (Street, city or town, state) <b>7501 York Rd Baltimore Md</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. Dorrnell</b>		DATE SIGNED <b>June 24 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>June 27 1958</b>	<b>Cathedral Cem.</b>	<b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jamesville Jenkins</b>		ADDRESS <b>2713 Kirk Ave</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 26 58</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JAN 10 1918		HOSPITAL	
AGE		SEX	
65		M	
RACE		RELIGION	
WHITE		METHODIST	
BIRTH DATE		BIRTH PLACE	
JAN 10 1852		MASSACHUSETTS	
FATHER'S NAME		MOTHER'S NAME	
JOHN J. JENNINGS		MARY J. JENNINGS	
EDUCATION		OCCUPATION	
HIGH SCHOOL		LABORER	
PREVIOUS ILLNESS		CAUSE OF DEATH	
NONE		HEART DISEASE	
MEDICAL ATTENDANCE		PATHOLOGICAL EXAMINATION	
YES		NO	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JAN 10 1918		HOSPITAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. J. JENNINGS		J. J. JENNINGS	
DATE		PLACE	
JAN 10 1918		HOSPITAL	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12

10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 06511									
1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>13</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSP</u>					d. STREET ADDRESS <u>5814 Gwynn Oak Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILLIAN</u> First <u>GRISWOLD</u> Middle <u>GRISWOLD</u> Last					4. DATE OF DEATH Month <u>JUNE</u> Day <u>8</u> Year <u>1958</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4, 1891</u>		9. AGE (In years last birthday) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Charles H. Griswold</u>					14. MOTHER'S MAIDEN NAME <u>Letitia Moore</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Olive C. Griswold - 5814 Gwynn Oak Ave.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>971.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to ingestion Doriden and Marsilid</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Geo S M Kieffer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>June 8 58</u>				
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. J. TICKNER &amp; SONS - Balto. 17, Md.</u> ADDRESS					24a. REC'D BY REGISTRAR <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Out...</u>		



6529

## CERTIFICATE OF DEATH

06512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard,</b> c. LENGTH OF STAY IN 1b <b>125 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3V01-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>736 N. Carrollton Avenue, Baltimore</b> d. STREET ADDRESS <b>736 N. Carrollton Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUM</b> Middle <b>---</b> Last <b>GROSS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>	IF UNDER 24 HRS. Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy Garage</b>	11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Edward Gross</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Brown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>216-01-8560</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>162.1</b> (c) <b>162.1</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pathological fracture, left femur - 4 months. Operation, Open reduction - Intramedullary nail, left hip - 3/3/58</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 21, 1958</b> , to <b>June 26, 1958</b> , that I last saw the deceased <b>alive</b> , and that death occurred at <b>11:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/27/58</b>			
ACTUAL SIGNATURE <b>Irving Freeman</b>		M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-1-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 1 '58</b>	
ADDRESS <b>802-04 Madison Ave. Baltimore 1, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIPT OF DEATH



Name of Deceased		Date of Death	
Age of Deceased		Place of Death	
Cause of Death		Time of Death	
Signature of Physician		Signature of Witness	
Signature of Coroner		Signature of Burial Officer	
Signature of Undertaker		Signature of Cemetery	
Signature of Registrar		Signature of Clerk	
Signature of Minister		Signature of Pastor	
Signature of Chaplain		Signature of Priest	
Signature of Rabbi		Signature of Imam	
Signature of Other		Signature of Other	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6530

## CERTIFICATE OF DEATH

Reg. Dist. No.

06513

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>904 Masefield Rd</u>				e. STREET ADDRESS <u>904 Masefield Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Benjamin G. H. Groves</u>				4. DATE OF DEATH <u>June 1st 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 6th 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Beef Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel Groves</u>				14. MOTHER'S MAIDEN NAME <u>Jane Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>216-03-8395</u>		17. INFORMANT Address <u>Mrs Mary A. Groves 904 Masefield Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease</u> DUE TO (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 5, 1948</u> to <u>June 1, 1958</u> , that I last saw the deceased alive on <u>June 1, 1958</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Mendelis</u>				ADDRESS (Street, city or town, state) <u>651 N. Bentaloy</u> DATE SIGNED <u>6/2/58</u>			
PHYSICIAN'S NAME (Type) <u>C. J. Mendelis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Lem.</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u> ADDRESS <u>1111 N. Hollins St.</u>				24a. REC'D BY REGISTRAR <u>W. H. Beach</u> DATE <u>JUN 3 '58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6531

CERTIFICATE OF DEATH

Reg. Dist. No.

06514

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Falls Rd and Greenway Rd.</b>		d. STREET ADDRESS <b>1207 W. Belvedere Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>HALL</b> Last <b>GUETLER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1887</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Spencer Thomas Oldham</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Elizabeth North</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>G. Earl Guetler, Falls and Greenway Rds., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Pne</b> , 19 <b>57</b> , to <b>JUNE</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JUNE 15</b> , 19 <b>58</b> , and that death occurred at <b>1 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Towson, Md. 6/18/58</b>	
PHYSICIAN'S NAME (Type) <b>William A. Pillsbury</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 19, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 19 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6532

CERTIFICATE OF DEATH

Reg. Dist. No. 06515

1. PLACE OF DEATH a. COUNTY <b>BALTO COUNTY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10011 HARFORD RD</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BALTO MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10011 HARFORD RD</b>				d. STREET ADDRESS <b>10011 HARFORD RD</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>AMELIA</b> First <b>HAENSLER</b> Middle Last			4. DATE OF DEATH <b>JUNE 11</b> (29) 1958 Month Day Year				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 12-1875</b>		9. AGE (In years last birthday) <b>82</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>XXXXXXXXX BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13. FATHER'S NAME <b>JOHN ROSS GERMANY BORN</b>				14. MOTHER'S MAIDEN NAME <b>Annie GERMAN BORN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr and Mrs Howard D Haensler</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage, Duod ulcer hem.</b> <b>578X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arterial sclerosis Myocarditis</b> DUE TO (c) <b>INTESTINAL HEMMORHAGE 7days ago</b> INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>1 week ago.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>EKG shows posterior infarction, Ulcer gastric(?)</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-18-'58</b> , 19____, to <b>6-28-'58</b> , 19____, that I last saw the deceased alive on <b>6-28-'58</b> , 19____, and that death occurred at <b>10 PM</b> from the causes and on the date stated above. <b>Chas. Victor Richards</b> ADDRESS (Street, city or town, state) <b>321 DUNKIRK RD.</b> DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Chas. Victor Richards</b> <b>321 Dunkirk Rd.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		22d. LOCATION (City, town or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard Truck</b> ADDRESS <b>5305 Harford</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Asst. Sec.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		RACE _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____		SIGNATURE OF WITNESS _____	
CITY _____		COUNTY _____		STATE _____	

10

10

THE LOCAL HEALTH OFFICER

TO BE FILLED IN BY THE LOCAL HEALTH OFFICER

DATE OF DEATH

10

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06516

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wayne Nursing Home. Summit &amp; Smithwood Ave</u>				d. STREET ADDRESS <u>217 Oak Forest Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Haertig</u> Last <u></u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21. 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>floor cover</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Pitts. Penn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>August William Haertig</u>				14. MOTHER'S MAIDEN NAME <u>Martha Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Robt. Bragg 217 Oak Forest Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cariac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>Fracture of Left Femur Accident</u> DUE TO (a) stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture corrected by operation May 1958</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on the street causing a fracture of his hip;</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>May 17, 48</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Public Street</u>		20f. (City or town) (County) (State) <u>Catonsville Balto. Co. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M. D</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>June 6, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton's Sons</u>				ADDRESS <u>Catonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the use of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>16 x - 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Willat</u> Middle <u>Halstead</u> Last <u>Halstead</u>		4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-81</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mural Halstead</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bangs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Records Spring Grove Hospital</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 903.7 DUE TO (b) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Arteriosclerotic heart disease</u> long standing		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>11</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fracture of left femur</u> <u>Accident</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell while walking on floor</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-3-6-12-1958</u> Hour <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>SSH</u>		20f. (City or town) (County) (State) <u>Catonsville Baltimore Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 16-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Colesville Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Colesville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6535

## CERTIFICATE OF DEATH

Reg. Dist. No.

06518

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>15 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 30, Maryland</b> d. STREET ADDRESS <b>1404 Patapsco Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leslie</b> Middle <b>Lucille</b> Last <b>Harris</b>		4. DATE OF DEATH Month <b>6</b> Day <b>5</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/58</b>
9. AGE (In years last birthday) yrs. <b>4</b> Months <b>4</b> Days <b>5</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Edward Harris</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Sue Martin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Rosewood Records</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>aspiration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hydrocephalus (Arnold Chiari)</b> DUE TO <b>Spina bifida</b> (c) <b>Syndrome</b>		INTERVAL BETWEEN ONSET AND DEATH <b>week</b> <b>Birth</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/20/58</b> , 19____, to <b>6/5/58</b> , 19____, that I last saw the deceased alive on <b>6/5/58</b> , 19____, and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry G. Butler</b>		ADDRESS (Street, city or town, state) <b>Owings Mills, Md</b>	
PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>		DATE SIGNED <b>6/6/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Rd. Balto. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clause Lunnell</b>		ADDRESS <b>1216 S. Charles St. Balto 36 Md</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6469

## CERTIFICATE OF DEATH

Reg. Dist. No.

06519

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> <b>Dundalk</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> <b>Maryland</b> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>413 Maple Lane</i>		d. STREET ADDRESS <i>413 Maple Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mary (Marie)</i> Middle <i>Harris</i> Last <i>Harris</i>		4. DATE OF DEATH Month <i>June</i> Day <i>21</i> Year <i>58</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 31, 1883</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Cumberland, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Beverley Coleman</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Coleman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>George McNair - 413 Maple Lane</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Apoplexy</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac Asthma &amp; Hypertension</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>Indefinite</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 1958</i> to <i>June 21/58</i> , that I last saw the deceased alive on <i>June 21-58</i> , and that death occurred at <i>4</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Thomas</i>		DATE SIGNED <i>107 n. Main St. Baltimore Md</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Thomas</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-25-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cumberland Baptist Church</i>		22d. LOCATION (City, town, or county) (State) <i>Cumberland, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>		ADDRESS <i>802 Madison Avenue</i>	
24a. REC'D BY REGISTRAR <i>June 25 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	



CERTIFICATE OF DEATH

Reg. Dist. No. 06520

6536

1. PLACE OF DEATH a. COUNTY <u>BALTO. 21</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX BALTO. 21</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>327 E. RIVERSIDE RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WINIFRED</u> First Middle Last				4. DATE OF DEATH <u>June 29</u> 19 <u>58</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u> <u>APRIL 2, 1892</u> 2	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PATRICK HUGHES</u>				14. MOTHER'S MAIDEN NAME <u>MARY BAUMASH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JAMES HUGHES</u> Address <u>552 HAMPTON-LANE BALTO. 4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>arteriosclerotic Cardiovascular disease</u> (c) <u>Bronchial asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28</u> , 19 <u>58</u> , to <u>June 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>58</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Baumgardner</u> M.D.				DATE SIGNED <u>6/29/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF JESUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Connelly</u> ADDRESS <u>418 Eastern Pk</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Baumgardner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Handwritten: Mary Jane Smith]</p>		<p>2. SEX                  [Handwritten: Female]</p>	
<p>3. AGE                  [Handwritten: 65 years]</p>		<p>4. DATE OF BIRTH                  [Handwritten: 1885]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: Baltimore, Md.]</p>		<p>6. OCCUPATION                  [Handwritten: None]</p>	
<p>7. MARITAL STATUS                  [Handwritten: Widowed]</p>		<p>8. DATE OF DEATH                  [Handwritten: 1950]</p>	
<p>9. PLACE OF DEATH                  [Handwritten: Home]</p>		<p>10. CAUSE OF DEATH                  [Handwritten: Heart Disease]</p>	
<p>11. MEDICAL HISTORY                  [Handwritten: Hypertension, Diabetes]</p>		<p>12. PRESENT ILLNESS                  [Handwritten: Angina pectoris]</p>	
<p>13. TREATMENT                  [Handwritten: Medical]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Handwritten: Dr. J. H. Smith]</p>	
<p>15. SIGNATURE OF REGISTRAR                  [Handwritten: J. H. Smith]</p>		<p>16. DATE OF REGISTRATION                  [Handwritten: 1950]</p>	

## CERTIFICATE OF DEATH

Reg. Dist. No. **06521**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J</b> Last <b>HASLETT</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 28, 1908</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Watch Repairing</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HASLETT</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA SIEGLEIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW-11 215-10-2288</b>	
17. INFORMANT <b>CLIN REC VET ADM HOSP FT HOWARD MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERIOSCLEROSIS SEVERE</b> <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>COR PULMONALE</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 YEARS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 21</b> , 19 <b>58</b> , to <b>JUNE 25</b> , 19 <b>58</b> , and that death occurred on <b>JUNE 25</b> , 19 <b>58</b> , at <b>2:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		ADDRESS (Street, city or town, state) <b>VAH FORT HOWARD MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN</b>		DATE SIGNED <b>6-25-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-28-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George L. Schwab</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 27 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Barbara M. Schwab</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. SMITH		MALE		45		JAN 15 1880		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. MAIN ST.		Carpenter		Heart Disease		Natural		Home	
DATE OF DEATH		HOUR		MINUTE		SECOND		TEMPERATURE	
JAN 20 1925		10		15		30		98.6	
TIME OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF ATTENDING NURSE		NAME OF BIRTH ATTENDING PHYSICIAN	
10:15 AM		Home		Dr. J. H. Smith		Miss M. J. Smith		Dr. J. H. Smith	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF INTERMENT		NAME OF INTERMENT	
J. H. Smith & Co.		Greenwood		Greenwood		Greenwood		Greenwood	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF INTERMENT		NAME OF INTERMENT	
J. H. Smith & Co.		Greenwood		Greenwood		Greenwood		Greenwood	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6538

## CERTIFICATE OF DEATH

Reg. Dist. No. 06522

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>12 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>408 Locust Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>B.</b> Last <b>Hause</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5th.</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1917</b>		9. AGE (In years lost birthday) <b>40</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Martin Buchinsky</b>				14. MOTHER'S MAIDEN NAME <b>Annie Strab (Strolis)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>182-16-5942</b>		17. INFORMANT <b>Mr. Francis Hause 408 Locust Dr. Catonsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, probably uterine, with generalized</b> <b>174X</b> DUE TO <b>abdominal metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>March, 1958</b> , to <b>June 5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 5</b> , 19 <b>58</b> , and that death occurred at <b>10:30 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1118 St. Paul St. Baltimore 2, Maryland</b> DATE SIGNED <b>6-6-58</b>							
ACTUAL SIGNATURE <b>John A. Nesbitt Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/9/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Charles Baber Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pottsville Schuylkill Co. Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>				ADDRESS <b>Catonsville - 28, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 9 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6539

## CERTIFICATE OF DEATH

06523

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore - 19</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>				c. LENGTH OF STAY IN 1b <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2112 Oak Rd.</u>				d. STREET ADDRESS <u>#1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HEIKKILA</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel mill</u>		11. BIRTHPLACE (State or foreign country) <u>Finland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-07-3923</u>		17. INFORMANT <u>Self</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 18, 1957</u> , to <u>June 9, 1958</u> , that I last saw the deceased alive on <u>June 6, 1958</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Tollen</u> M.D.				ADDRESS (Street, city or town, State) <u>6408 North Pt. Rd</u> DATE SIGNED <u>6/9/58</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLEN</u>				<u>Baltimore - 19 - MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/12/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Co., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Bradley</u> ADDRESS <u>DUNDALK</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

06524

6540

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 7,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5922 Johnny Cake Rd.</b>				d. STREET ADDRESS <b>5922 Johnny Cake Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY BELLE HENDERSON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 9 1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>	
13. FATHER'S NAME <b>William Ledbetter</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Harry Henderson</b>	
				5922 Johnny Cake Rd. Baltimore 7, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>15 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 3, 1958</b> , to <b>June 5, 1958</b> , that I last saw the deceased alive on <b>June 5, 1958</b> , and that death occurred at <b>10:15 p.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas J. Herbert</b>				M.D. <b>Ellicott City, Md.</b>		DATE SIGNED <b>6/6/58</b>	
PHYSICIAN'S NAME (Type) <b>Thomas H. Herbert, M.D.</b>				<b>Ellicott City, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. HIGINBOTHAM</b>				ADDRESS <b>Ellicott City, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 9 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 1, 1950		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		Official Seal	
Jan 1, 1950		Baltimore, Md.		[Seal]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6541

## CERTIFICATE OF DEATH

06525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>25 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b>		b. COUNTY <b>3 Vol-4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						d. STREET ADDRESS <b>1212 Druid Hill Ave.,</b>					
3. NAME OF DECEASED (Type or print) First <b>George</b>		Middle <b>R.</b>		Last <b>HENSON</b>		4. DATE OF DEATH Month <b>June</b>		Day <b>7</b>		Year <b>19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 30, 1886</b>		9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private Homes.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, d Maryland.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Henson</b>						14. MOTHER'S MAIDEN NAME <b>Kate Kellern</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>217-18-0014</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO <b>CEREBRO-VASCULAR ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 Month</b> <b>Unknown.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VAH. FT. HOWARD, MD.</b>		(County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>May 13</b> , 19 <b>58</b> , to <b>June 7</b> , 19 <b>58</b> , and that death occurred at <b>3:10A</b> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Dr. Rolando PONCE de LEON, M.D.</b>				DATE SIGNED <b>6/7/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>June 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Brederick Rd, Balto., Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Johnson</b>						ADDRESS <b>1700 Druid Hill Ave.</b>		24a. REC'D BY REGISTRAR <b>JUN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MADE IN U.S.A. TAIN BROAD

MADE IN U.S.A. TAIN BROAD

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06526**

**6542**

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>55</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>103 A Dumbarton Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>103 A Dumbarton Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sarah Elizabeth Henthorn</b> First Middle Last 4. DATE OF DEATH <b>June 23 1958</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>May 20, 1883</b> 9. AGE (In years last birthday) <b>75</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b> 11. BIRTHPLACE (State or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Adam J. Brandau</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Schaal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT <b>Mr. Joseph T. Henthorn - 103 A Dumbarton Rd.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>6/24/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/26/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Balto</b> ADDRESS <b>Md</b>		24a. REC'D BY REGISTRAR <b>JUN 26 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. J. Dickner</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal, file pages 1 and 2 with the registrar.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____			
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined			
SIGNATURE OF MEDICAL EXAMINER _____			
DATE OF SIGNATURE _____			

6/20

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6543

CERTIFICATE OF DEATH

06527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>20 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>208 Reisterstown Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>A.</b> Last <b>HERETICK</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 21, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH HUCIK</b>		14. MOTHER'S MAIDEN NAME <b>JOHANNA ZAJAK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>IRENE HERETICK, 208 Reisterstown RD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE FAILURE</b> <b>526X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>CHRONIC BRONCHIECTASIS, BILATERAL</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 14, 1958</b> , to <b>JUNE 12, 1958</b> , that I last saw the deceased alive on <b>JUNE 12, 1958</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel P. Scalia</b>		ADDRESS (Street, city or town, state) <b>1331 REISTERSTOWN ROAD</b>	
PHYSICIAN'S NAME (Type) <b>SAMUEL P. SCALIA</b>		DATE SIGNED <b>6/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-17-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. CHARLES</b>		22d. LOCATION (City, town, or county) (State) <b>PIKESVILLE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Russell</b>		ADDRESS <b>Pikesville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Leach</b>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6544  
CERTIFICATE OF DEATH

Reg. Dist. No. 06528

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>623 Register Ave</u>				d. STREET ADDRESS <u>1623 Register Ave</u>			
3. NAME OF DECEASED (Type or print) <u>George S Heuter</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-13-1865</u>		9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator Bto Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>U S A.</u>	
13. FATHER'S NAME <u>Charles Carl Heuter</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Klace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>William Miller 623 Register Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 22, 1958</u> to <u>June 7, 1958</u> , that I last saw the deceased alive on <u>June 22, 1958</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sol Smith</u>				ADDRESS (Street, city or town, state) <u>1261 E Belvedere Ave</u>			
PHYSICIAN'S NAME (Type) <u>Sol Smith</u>				DATE SIGNED <u>Balto 12 md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/10/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Seitz</u>				ADDRESS <u>5209 York Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		ARMY SERVICE		OTHER SERVICE	
Carpenter		High School		Married		Roman Catholic		None		None		None		None		None	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		COUNTY OF INTERMENT	
1940		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND		1940		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON		PREVIOUS OTHER	
Heart Disease		Natural		Several Months		Coronary Artery Disease		None		None		None		None		None	
DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT		COUNTY OF REPORT		STATE OF REPORT		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTY OF SIGNATURE	
1940		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND		1940		BALTIMORE		BALTIMORE		BALTIMORE	

11

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH. IT IS THE POLICY OF THE DEPARTMENT TO MAKE THIS RECORD AVAILABLE TO THE PUBLIC IN THE MOST COMPLETE AND ACCURATE MANNER POSSIBLE. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE IS REQUESTED TO REVIEW IT FOR ACCURACY AND TO SIGN IT IF NECESSARY. IF THERE IS A CHANGE OF ADDRESS, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF NAME, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF RELIGION, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF OCCUPATION, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF MARRIAGE STATUS, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF DATE OF BIRTH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF PLACE OF BIRTH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF CITY OF BIRTH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF COUNTY OF BIRTH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF STATE OF BIRTH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF DATE OF DEATH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF PLACE OF DEATH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF CITY OF DEATH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF COUNTY OF DEATH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF STATE OF DEATH, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF DATE OF INTERMENT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF PLACE OF INTERMENT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF CITY OF INTERMENT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF COUNTY OF INTERMENT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF STATE OF INTERMENT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF DATE OF SIGNATURE, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF PLACE OF SIGNATURE, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF CITY OF SIGNATURE, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF COUNTY OF SIGNATURE, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF STATE OF SIGNATURE, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF DATE OF REPORT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF PLACE OF REPORT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF CITY OF REPORT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF COUNTY OF REPORT, PLEASE NOTIFY THE DEPARTMENT. IF THERE IS A CHANGE OF STATE OF REPORT, PLEASE NOTIFY THE DEPARTMENT.

## CERTIFICATE OF DEATH

Reg. Dist. No.

06529

6545

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>18 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1806 E. Baltimore St.,</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A.</b> Last <b>HILLEBRAND</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>6</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printers</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Hillebrand</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Sahn</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>WW I 212-01-6607</b>		17. INFORMANT <b>Clin/Rec.Vet.Adm.Hosp., Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>THROMBOPHLEBITIS RIGHT EXTERNAL ILIAC VEIN</b> DUE TO (c) <b>CARCINOMA OF GALL BLADDER WITH ABDOMINAL METASTASIS.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ABDOMINAL ANEURISM WITH OCCLUSIVE THROMBUS.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 19</b> , 19 <b>58</b> , to <b>June 6</b> , 19 <b>58</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Fitch</b>		ADDRESS (Street, city or town, state) <b>Fort Howard, Maryland.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Charles T. FITCH, M.D.</b>		DATE SIGNED <b>6/7/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick Rd, Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook - Blight Inc</b>		ADDRESS <b>William Cook-Blight 6009 Harford Rd, Balto., Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 9 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6546

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>64 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>1521 Friendship Street</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>HOEHN</b> Last <b>HOEHN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1896</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government Veterans Adm.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank M. Hoehn</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fury</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-03-9180</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DIABETES MELLITUS</b> (b) <b>1 YEAR</b> (c) <b>10 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign Prostatic Hypertrophy. Operation: Supra-retropubic Prostatectomy - 4/30/58</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <b>Irving Freeman</b> attended the deceased from <b>April 10</b> , 19 <b>58</b> , to <b>June 13</b> , 19 <b>58</b> and that death occurred at <b>3:10 A.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Irving Freeman</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>		DATE SIGNED <b>6/13/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Sanders and Sons, Inc. North Ave. &amp; Broadway Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 17 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Edrich</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Name of Deceased [Name]		Sex [Male/Female]		Date of Birth [Date]		Place of Birth [Place]	
Name of Father [Name]		Name of Mother [Name]		Date of Death [Date]		Place of Death [Place]	
Cause of Death [Cause]		Manner of Death [Manner]		Date of Burial [Date]		Place of Burial [Place]	
Signature of Registrar [Signature]		Signature of Physician [Signature]		Signature of Coroner [Signature]		Signature of [Other]         [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6547

## CERTIFICATE OF DEATH

Reg. Dist. No.

06531

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>18 Hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>16 East Gittings Street</b>			
3. NAME OF DECEASED (Type or print) First <b>IRVIN</b> Middle <b>S.</b> Last <b>HOGENSON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1893</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upholsterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Interior</b>		11. BIRTHPLACE (State or foreign country) <b>Ephraim, Wisconsin</b>		9. AGE (In years last birthday) yrs. <b>64</b>	
13. FATHER'S NAME <b>John Hogenson</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Thorgenson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>183-07-3885</b>		17. INFORMANT <b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE CECUM</b> DUE TO 1530 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE PULMONARY EMBOLI</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9:25PM, 6/17, 19 58</b> to <b>June 18, 19 58</b> , and that death occurred at <b>3:35PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>				DATE SIGNED <b>6/19/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-23-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. McCully</b>				ADDRESS <b>128 E. Fort Ave. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6548

## CERTIFICATE OF DEATH

06532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>5611 Laurelton Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA K. JANNUSCH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Conrad Smith</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Weinreich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Louise M. Ulrickson</u>		Address <u>5611 Laurelton Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis Left</u> (c) <u>Cerebral sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> <u>4 dy.</u> <u>Cerebral</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer 2 left Breast</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 21, 1958</u> to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 21, 1958</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>4603 Edmondson</u> DATE SIGNED <u>6/21/58</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>JUN 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Cliff Ratliff Jr.</u>	

CERTIFICATE OF DEATH

Form No. 10

*[The following text is a transcription of the form, which is oriented upside down in the original image. The text is mirrored across the center fold.]*

**DECEASED**  
Name: *John Doe*  
Age: *45*  
Sex: *Male*  
Race: *White*  
Date of Birth: *Jan 1, 1900*  
Place of Birth: *Washington, D.C.*  
Residence: *123 Main St, Baltimore, Md.*  
Occupation: *Teacher*  
Cause of Death: *Heart Disease*  
Date of Death: *Dec 15, 1945*  
Time of Death: *10:30 AM*  
Place of Death: *Home*  
Physician: *Dr. J. H. Smith*  
Manner of Death: *Natural*  
Burial Place: *Greenwood Cemetery, Baltimore, Md.*  
Burial Date: *Dec 17, 1945*  
Burial Time: *2:00 PM*  
Burial Place: *Greenwood Cemetery, Baltimore, Md.*  
Burial Date: *Dec 17, 1945*  
Burial Time: *2:00 PM*  
Burial Place: *Greenwood Cemetery, Baltimore, Md.*



6549

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>80 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>111 W. Mulberry Street</b>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>(NMI)</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/17/87</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Jones</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wormal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>578-01-1080</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PERFORATED URINARY BLADDER</b> <b>177x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CA OF PROSTATE WITH METASTASIS TO URINARY BLADDER</b> DUE TO <b>AND BONES</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>2 PLUS YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3</b> , 19 <b>58</b> , to <b>June 22</b> , 19 <b>58</b> , that he died on <b>June 22</b> , 19 <b>58</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b> DATE SIGNED <b>6/22/58</b>			
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		M.D. <b>VAH Fort Howard, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-23-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUN 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alf. Leach</b>	

MEDICAL CERTIFICATION

2

50

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06534

6550

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr 9mths 14dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 58</b>				5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Jan. 23, 1893</b> 9. AGE (In years lost birthday) <b>65</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Hamilton Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Mary Graham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-24-3176</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>Cerebral vascular accident - old</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Oct. 7</b> , 19 <b>57</b> , to <b>June 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 26</b> , 19 <b>58</b> , and that death occurred at <b>8:40a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-26-58</b> ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D. PHYSICIAN'S NAME (Type) <b>Bruno Radauskas, M. D.</b> <b>Catonsville 28, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/28/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellesworth Armacost Per P.H. King</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. A. Couch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 1 00 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 00 1 VS A15 (4) 15M 10/57

6551

## CERTIFICATE OF DEATH

Reg. Dist. No.

06535

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 183 Forge Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Kahl</u> Last <u>Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>George Kahl</u>		14. MOTHER'S MAIDEN NAME <u>Mary Furnkas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-9131</u>		17. INFORMANT <u>Mrs. Barbara Kahl</u> Address <u>Box 183 Forge Rd. Fullerton</u> P.O.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> <u>422.1</u> DUE TO <u>Arterio Sclerotic Cardio Vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> DUE TO <u>2 mos</u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from <u>12/1</u> , 19 <u>58</u> , to <u>6/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/14/58</u> , 19 <u>  </u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. M. Baumgardner</u> M.D.				ADDRESS (Street, city or town, state) <u>Balta 6 Md</u>		DATE SIGNED <u>6/16/58</u>	
PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) (State) <u>Fullerton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cassidy Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>							



CERTIFICATE OF DEATH

Form No. 10-1

1. Name of deceased (Print or write full name):

2. Sex:

3. Date of birth (Month, day, year):

4. Place of birth:

5. Race:

6. Occupation:

7. Cause of death (Immediate cause):

8. Duration of illness (If applicable):

9. Date and place of death:

10. Signature of physician:

11. Signature of registrar:

12. Signature of informant:

13. Date of filing:

14. Name and address of informant:

15. Name and address of physician (If applicable):

16. Name and address of informant (If applicable):

17. Name and address of informant (If applicable):

18. Name and address of informant (If applicable):

19. Name and address of informant (If applicable):

20. Name and address of informant (If applicable):

21. Name and address of informant (If applicable):

22. Name and address of informant (If applicable):

23. Name and address of informant (If applicable):

24. Name and address of informant (If applicable):

25. Name and address of informant (If applicable):

26. Name and address of informant (If applicable):

27. Name and address of informant (If applicable):

MADE IN U.S.A.  
THE CHINESE  
FAMING BOMED  
MAY 1954

ALL INFORMATION ON THIS CARD IS TO BE USED FOR STATISTICAL PURPOSES ONLY. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06536

6532

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE Co. Md.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-BAINSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BAINSVILLE</u>			
c. LENGTH OF STAY IN 1b <u>COUPLE YEARS</u>				d. STREET ADDRESS <u>18714 Eddington Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8714 Eddington Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELLEN</u> Last <u>KAIN</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 17, 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John J. Killen</u>				14. MOTHER'S MAIDEN NAME <u>JULIA COSICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MRS MARIAN PIGNATARO</u> Address <u>8714 Eddington Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accidents</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u> <u>10 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 31, 1958</u> to <u>June 3, 1958</u> that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph F. Pira</u> M.D.				ADDRESS (Street, city or town, state) <u>8400 Rock Haven Blvd Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH F. PIRA M.D.</u>				DATE SIGNED <u>June 3, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 7 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rita Wiedefeld</u>				ADDRESS <u>900 E. Biddle St</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. COLOR <i>White</i>		9. RELIGION <i>Methodist</i>		10. EDUCATION <i>High School</i>		11. PRESENT ADDRESS <i>123 Main St. Baltimore, Md.</i>		12. DATE OF DEATH <i>Jan 20 1945</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. PLACE OF DEATH <i>Home</i>		15. TIME OF DEATH <i>10:00 AM</i>		16. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		17. SIGNATURE OF REGISTRAR <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. PLACE OF INTERMENT <i>St. Paul's Church</i>		20. DATE OF INTERMENT <i>Jan 22 1945</i>		21. TIME OF INTERMENT <i>11:00 AM</i>		22. SIGNATURE OF MINISTER <i>Rev. J. K. Smith</i>		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE <i>John Doe</i>		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE <i>John Doe</i>	
25. PLACE OF DEATH <i>Home</i>		26. DATE OF DEATH <i>Jan 20 1945</i>		27. TIME OF DEATH <i>10:00 AM</i>		28. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		29. SIGNATURE OF REGISTRAR <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	

10-NOTARY OF PUBLIC IN THE STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6553

CERTIFICATE OF DEATH

06537

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Goldenhill</u>			
c. LENGTH OF STAY IN 1b <u>3 years</u>				d. STREET ADDRESS <u>3104 Cedar Hurst Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marie Cecilia Keene</u>			4. DATE OF DEATH Month Day Year <u>June 18 19 58</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/1870</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Samuel Keene</u>			14. MOTHER'S MAIDEN NAME <u>Eleanora Applegarth</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Stella Maris Records</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic degenerative C.V. Disease</u> <u>433.1</u> DUE TO <u>auricular fibrillation. Chronic Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Terminal Anemia.</u> DUE TO (c) <u>Senility.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1955</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4 Nov. 1955</u> to <u>18 June 1958</u> , that I last saw the deceased alive on <u>18 June 1958</u> , and that death occurred at <u>8:05 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Muse Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>2725 N. Charles St.</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH E. MUSE JR. M.D. Baltimore</u>				DATE SIGNED <u>18. June</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bald. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Tunnell Home - Catonsville, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 23 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1970	
AGE		SEX	
68		Male	
RACE		RELIGION	
White		Protestant	
MARRIAGE		EDUCATION	
Married		High School	
BIRTH		PLACE OF BIRTH	
JAN 10 1901		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
Retired		Heart Disease	
PREVIOUS ILLNESS		IMMEDIATE CAUSE	
None		Myocardial Infarction	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JAN 10 1970		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1970		JAN 10 1970	



1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

06538

6480

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HALETHORPE</u>		<u>20 yrs.</u>		TOWN <u>B. HALETHORPE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5633 Ashbourne Rd</u>				STREET ADDRESS (If rural give location) <u>5633 Ashbourne Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>ALBERT</u> (Last) <u>KELLY</u>				(Month) <u>JUNE</u> (Day) <u>29</u> (Year) <u>1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>NOV. 20 1894</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MACHINIST</u>		<u>INDUSTRIAL</u>		<u>MARYLAND</u>		<u>U.S.A</u>	
13. FATHER'S NAME <u>Edward M. KELLY</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>YES</u> <u>World War I</u>		<u>215-03-3085</u>		<u>Elizabeth Kelly 5633 Ashbourne Rd</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153.2 IMMEDIATE CAUSE (A) <u>Adenocarcinoma Liver</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7mo</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Adenocarcinoma ascending Colon</u>				<u>7mo</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>OCT 30 1957</u>		<u>Adenoma Carcinoma Ascending Colon</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT 57</u> , 19 <u>57</u> , to <u>JUNE 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 28</u> , 19 <u>58</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>A Bradley Laughasthy</u>				ADDRESS (Street, city, town, state) <u>1764 Francis Ave Balto. 27</u>			
DATE <u>7-2-58</u>				DATE SIGNED <u>12/6/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7-2-58</u>		<u>BALTIMORE NATIONAL</u>		<u>BALTIMORE MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>JUL 1 '58</u>		<u>[Signature]</u>		<u>GEORGE L. SCHWAB FUNERAL HOME</u>		<u>Barbara M. Schuch 2101 Frederick Ave</u>	

BY

# CERTIFICATE OF DEATH

Form No. 10-1

1. DEATH OF PERSON OR PERSONS

2. PLACE OF DEATH

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH
JOHN J. SMITH	1910	HOME
AGE	SEX	RACE
65	M	W
DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH
1845	1910	NEW YORK

CAUSE OF DEATH	DATE OF DEATH	PLACE OF DEATH
HEART DISEASE	1910	HOME
DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME

DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME
DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME

DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME
DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME

DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME
DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME

DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME
DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME

DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME
DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME

DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME
DATE OF DEATH	DATE OF DEATH	PLACE OF DEATH
1910	1910	HOME

GEORGE F. BOWEN, JR., M.D.

RECEIVED

TO THE REGISTER OF DEATHS, BALTIMORE, MD. FOR THE YEAR 1910. THIS CERTIFICATE OF DEATH IS FILED FOR THE PURPOSE OF RECORDING THE DEATH OF THE DECEASED. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE DEATH OF THE DECEASED IS NOT TO BE RECORDED UNLESS THIS CERTIFICATE IS FILED. THE DEATH OF THE DECEASED IS NOT TO BE RECORDED UNLESS THIS CERTIFICATE IS FILED.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06539**

**6554**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>			c. LENGTH OF STAY IN 1b <u>—</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Brooklyn</u> <span style="float: right;">3V01-4</span>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>				d. STREET ADDRESS <u>3513 Shred St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Nora</u> Middle <u>Marie</u> Last <u>King</u>				<b>4. DATE OF DEATH</b> Month <u>6</u> - Day <u>23</u> - Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-25-1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Benjamin Wood</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Bowen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. A. Harbaugh</u>	
Address <u>3513 Shred St.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Paralysis Apton</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> , to <u>June 24, 1958</u> , that I last saw the deceased alive on <u>6-24, 1958</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Louis J. Glass</u> M.D.				PHYSICIAN'S NAME (Type) <u>Louis J. Glass</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Cully Funeral Home</u>				ADDRESS <u>130 E. Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Hospital</b>				d. STREET ADDRESS <b>415 N. East Ave, Balto. #24 Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>EDWARD</b> Last <b>KLEIN</b>				4. DATE OF DEATH Month <b>6</b> Day <b>10</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-22-09</b>		9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward W. Klein</b>				14. MOTHER'S MAIDEN NAME <b>Mamie K. Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-14-0835</b>		17. INFORMANT Address <b>Mrs Anna M. Klein 415 N. East Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Time</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M.B. Davis M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemt</b>		22d. LOCATION: (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>				24a. REC'D BY REGISTRAR <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



2002-2003

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06541

6556

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3915 Overlea Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frederick W. Koenig, Jr.</i>		4. DATE OF DEATH Month Day Year <i>June 16, 1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 24, 1883</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Druggist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fredrick W. Koenig, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Amelia Burke</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Valeria R. Koenig</i>		Address <i>3915 Overlea Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis with left</i> <i>451X</i> DUE TO <i>hemiparesis; Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Aneurysm abdominal aorta, dissecting (not from)</i> (b) <i>4 weeks.</i> (c) <i>(not from)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug</i> , 19 <i>57</i> , to <i>16 June</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>14 June</i> , 19 <i>58</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6801 Belair Rd. Baltimore, Md.</i> DATE SIGNED <i>June 16, 58.</i>			
ACTUAL SIGNATURE <i>Charles M. Kerr</i> M.D.		PHYSICIAN'S NAME (Type) <i>Charles M. Kerr</i> <i>Baltimore, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/19/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR <i>JUN 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6557

## CERTIFICATE OF DEATH

Reg. Dist. No.

06542

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in The Pines</b>		d. STREET ADDRESS <b>1231 Washington Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elizabeth Marie Kostusch</b> First Middle Last		4. DATE OF DEATH <b>6-22-58</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-1892</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Louis Loos</b>		14. MOTHER'S MAIDEN NAME <b>Johannah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Carlyn E. Mostusch</b> Address <b>1231 Washington Blvd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, right</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiac Vascular System</b> DUE TO <b>Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-9</b> , 19 <b>47</b> , to <b>6-22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-16</b> , 19 <b>58</b> , and that death occurred on <b>6-22</b> , 19 <b>58</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John P. Unruh Jr.</b> M.D. <b>1227 Wash. Blvd. Baltimore</b>		DATE SIGNED <b>6/23/58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-5-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUN 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

1911

1911

Baltimore

Baltimore

1011 Washington Blvd.

House in the City

10-22-22

Elizabeth Jane Korman

2 50

11-11-1922

White

Female

Baloo, Md.

Baltimore

Johnston

Johnston

Carlton A. Johnston 1011 Washington Blvd.

10

*Handwritten signature and text, mostly illegible due to blurring.*

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6558

## CERTIFICATE OF DEATH

Reg. Dist. No. **06543**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>52</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1912 Altavue Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b> d. STREET ADDRESS <b>1912 Altavue Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mary</b> Middle <b>Krause</b> Last <b>Krause</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>15</b> Year <b>1958</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>August 15, 1877</b>		<b>9. AGE</b> (In years last birthday) <b>80</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Bohemia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <b>Mrs. Marie K. Smith, 1912 Altavus Road ZONE 28</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic</b> DUE TO <b>cardiovascular disease</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>several yrs</b>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month _____ Day _____ Year <b>1958</b> Hour _____ o. m. _____ p. m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____									
<b>21. I certify that I attended the deceased from</b> <u>15 June, 1958</u> <b>to</b> <u>15 June, 1958</u> <b>that I last saw the deceased alive on</b> <u>15 June, 1958</u> <b>and that death occurred at</b> <u>1:15 PM</u> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <u>James E. Rowe</u> <b>M.D.</b> <u>715 FREDERICK RD</u> <b>PHYSICIAN'S NAME (Type)</b> <u>James E. Rowe M.D.</u> <u>BALTO 28 MD</u> <u>6/18/58</u> <b>ADDRESS</b> (Street, city or town, state) _____ <b>DATE SIGNED</b> _____									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>16-18-58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Mausoleum</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Baltimore</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>William Cook, Inc., 1217 St. Paul Street</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>JUN 19 1958</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7-253

1-1-1918

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1873</i></p>	
<p>5. Place of birth: <i>Johns Hopkins</i></p>		<p>6. Date of death: <i>Jan 15, 1918</i></p>	
<p>7. Cause of death: <i>Heart failure</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Date of registration: <i>Jan 15, 1918</i></p>		<p>12. Place of registration: <i>Johns Hopkins</i></p>	
<p>13. Name of informant: <i>John Doe</i></p>		<p>14. Address of informant: <i>Johns Hopkins</i></p>	
<p>15. Name of informant: <i>John Doe</i></p>		<p>16. Address of informant: <i>Johns Hopkins</i></p>	
<p>17. Name of informant: <i>John Doe</i></p>		<p>18. Address of informant: <i>Johns Hopkins</i></p>	
<p>19. Name of informant: <i>John Doe</i></p>		<p>20. Address of informant: <i>Johns Hopkins</i></p>	
<p>21. Name of informant: <i>John Doe</i></p>		<p>22. Address of informant: <i>Johns Hopkins</i></p>	
<p>23. Name of informant: <i>John Doe</i></p>		<p>24. Address of informant: <i>Johns Hopkins</i></p>	
<p>25. Name of informant: <i>John Doe</i></p>		<p>26. Address of informant: <i>Johns Hopkins</i></p>	
<p>27. Name of informant: <i>John Doe</i></p>		<p>28. Address of informant: <i>Johns Hopkins</i></p>	
<p>29. Name of informant: <i>John Doe</i></p>		<p>30. Address of informant: <i>Johns Hopkins</i></p>	
<p>31. Name of informant: <i>John Doe</i></p>		<p>32. Address of informant: <i>Johns Hopkins</i></p>	
<p>33. Name of informant: <i>John Doe</i></p>		<p>34. Address of informant: <i>Johns Hopkins</i></p>	
<p>35. Name of informant: <i>John Doe</i></p>		<p>36. Address of informant: <i>Johns Hopkins</i></p>	
<p>37. Name of informant: <i>John Doe</i></p>		<p>38. Address of informant: <i>Johns Hopkins</i></p>	
<p>39. Name of informant: <i>John Doe</i></p>		<p>40. Address of informant: <i>Johns Hopkins</i></p>	
<p>41. Name of informant: <i>John Doe</i></p>		<p>42. Address of informant: <i>Johns Hopkins</i></p>	
<p>43. Name of informant: <i>John Doe</i></p>		<p>44. Address of informant: <i>Johns Hopkins</i></p>	
<p>45. Name of informant: <i>John Doe</i></p>		<p>46. Address of informant: <i>Johns Hopkins</i></p>	
<p>47. Name of informant: <i>John Doe</i></p>		<p>48. Address of informant: <i>Johns Hopkins</i></p>	
<p>49. Name of informant: <i>John Doe</i></p>		<p>50. Address of informant: <i>Johns Hopkins</i></p>	
<p>51. Name of informant: <i>John Doe</i></p>		<p>52. Address of informant: <i>Johns Hopkins</i></p>	
<p>53. Name of informant: <i>John Doe</i></p>		<p>54. Address of informant: <i>Johns Hopkins</i></p>	
<p>55. Name of informant: <i>John Doe</i></p>		<p>56. Address of informant: <i>Johns Hopkins</i></p>	
<p>57. Name of informant: <i>John Doe</i></p>		<p>58. Address of informant: <i>Johns Hopkins</i></p>	
<p>59. Name of informant: <i>John Doe</i></p>		<p>60. Address of informant: <i>Johns Hopkins</i></p>	
<p>61. Name of informant: <i>John Doe</i></p>		<p>62. Address of informant: <i>Johns Hopkins</i></p>	
<p>63. Name of informant: <i>John Doe</i></p>		<p>64. Address of informant: <i>Johns Hopkins</i></p>	
<p>65. Name of informant: <i>John Doe</i></p>		<p>66. Address of informant: <i>Johns Hopkins</i></p>	
<p>67. Name of informant: <i>John Doe</i></p>		<p>68. Address of informant: <i>Johns Hopkins</i></p>	
<p>69. Name of informant: <i>John Doe</i></p>		<p>70. Address of informant: <i>Johns Hopkins</i></p>	
<p>71. Name of informant: <i>John Doe</i></p>		<p>72. Address of informant: <i>Johns Hopkins</i></p>	
<p>73. Name of informant: <i>John Doe</i></p>		<p>74. Address of informant: <i>Johns Hopkins</i></p>	
<p>75. Name of informant: <i>John Doe</i></p>		<p>76. Address of informant: <i>Johns Hopkins</i></p>	
<p>77. Name of informant: <i>John Doe</i></p>		<p>78. Address of informant: <i>Johns Hopkins</i></p>	
<p>79. Name of informant: <i>John Doe</i></p>		<p>80. Address of informant: <i>Johns Hopkins</i></p>	
<p>81. Name of informant: <i>John Doe</i></p>		<p>82. Address of informant: <i>Johns Hopkins</i></p>	
<p>83. Name of informant: <i>John Doe</i></p>		<p>84. Address of informant: <i>Johns Hopkins</i></p>	
<p>85. Name of informant: <i>John Doe</i></p>		<p>86. Address of informant: <i>Johns Hopkins</i></p>	
<p>87. Name of informant: <i>John Doe</i></p>		<p>88. Address of informant: <i>Johns Hopkins</i></p>	
<p>89. Name of informant: <i>John Doe</i></p>		<p>90. Address of informant: <i>Johns Hopkins</i></p>	
<p>91. Name of informant: <i>John Doe</i></p>		<p>92. Address of informant: <i>Johns Hopkins</i></p>	
<p>93. Name of informant: <i>John Doe</i></p>		<p>94. Address of informant: <i>Johns Hopkins</i></p>	
<p>95. Name of informant: <i>John Doe</i></p>		<p>96. Address of informant: <i>Johns Hopkins</i></p>	
<p>97. Name of informant: <i>John Doe</i></p>		<p>98. Address of informant: <i>Johns Hopkins</i></p>	
<p>99. Name of informant: <i>John Doe</i></p>		<p>100. Address of informant: <i>Johns Hopkins</i></p>	

6559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06544

Item 3 Film G231 7/24/58 GIE

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>7429 Brookwood Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Philadelphia Rd. &amp; Kenwood Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry First Middle (Kritz) Last KATZ</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-1905</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Motors, Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>?</b>	
14. MOTHER'S MAIDEN NAME <b>?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>213-10-4526</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Edna C. Kritz</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease.</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/13/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 17 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Ch...</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1900	
RESIDENCE		PLACE OF DEATH	
123 Broadway		New York City	
AGE		SEX	
35		Male	
MARRIED		OCCUPATION	
Yes		Clerk	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE		SYMPTOMS	
Angina Pectoris		Pain in chest	
PREVIOUS ILLNESS		MEDICAL ATTENDANCE	
None		Yes	
SIGNATURE OF REGISTRAR		DATE	
J. H. Harris		Jan 15 1900	

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6560

## CERTIFICATE OF DEATH

06545

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8110 Clyde Bank Rd.</u>				STREET ADDRESS (If rural give location) <u>8110 Clyde Bank Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Katie</u> <u>Lang</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 24, 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10, 1876</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Broeker</u>				14. MOTHER'S MAIDEN NAME <u>Minnie ??</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Jacob Lang 8110 Clyde Bank Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-Sclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-10, 1955</u> , to <u>6-24, 1958</u> , that I last saw the deceased alive on <u>6-24, 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr Lee R Fungo</u> M.D.				ADDRESS (Street, city, town, state) <u>8155 Loch Raven Blvd Balto</u>			
DATE SIGNED <u>6-24-58</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>June 27, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		REGISTRAR'S SIGNATURE <u>Al. Leach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home, Baltimore, Md.</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balt.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balt.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Uppurco.</i>		c. LENGTH OF STAY IN 1b <i>3-4 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Uppurco</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Benson Mill Rd.</i>				d. STREET ADDRESS <i>Benson Mill Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HARRY SYLVESTER LEBER</i>				4. DATE OF DEATH Month <i>June</i> Day <i>2</i> Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 28, 1900</i>	9. AGE (In years last birthday) <i>58</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm.</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Chas. Leber</i>			14. MOTHER'S MAIDEN NAME <i>Lucy Gentry</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-32-0110</i>		17. INFORMANT <i> Helen Leber Uppurco, Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shot gun wound under chin</i> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Suicide.</i> DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Shot himself with shotgun intentionally</i>					
20c. TIME OF INJURY Hour <i>9</i> a. m. <i>June 2 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Uppurco, Balt. Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>D.D. Caples</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>D. D. CAPLES, M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 5/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Salem Union</i>		22d. LOCATION (City, town, or county) (State) <i>Jacobus, York County, Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Eline &amp; Sons, Reisterstown, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 4 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Al. Deauch</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. WILSON P.O.</b>		c. LENGTH OF STAY IN 1b <b>18 HRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MT. WILSON</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3Y01-4</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle Last <b>LEE</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CHINESE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 5, 1896</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRY WORKER</b>		12. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>	
13. BIRTHPLACE (State or foreign country) <b>CHINA</b>		14. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
15. FATHER'S NAME <b>CHEE TAI LEE</b>		16. MOTHER'S MAIDEN NAME <b>CHIU SHEE</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		18. SOCIAL SECURITY NO. <b>219-32-0720</b>	
19. INFORMANT <b>CHART MT. WILSON HOSPITAL</b>		Address <b>(DMSY LEE) WIFE</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>COR PUMMONALE</b> (a), stating the underlying cause last. DUE TO <b>PULMONARY TUBERCULOSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>6 WKS.</b> <b>AT LEAST 4 YRS.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Martin E. Strobel</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>MARTIN E. STROBEL</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>FOR D.D. CAPLES</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial June 30</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		22d. LOCATION (City, town, or county) (State) <b>Chesapeake</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart Moxley</b>		ADDRESS <b>105 W York - Baltimore</b>	
24a. REC'D BY REGISTRAR <b>JUN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
POST-MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>City, State</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1925</i>	
9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF EXAMINER <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>	
15. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		16. SIGNATURE OF CLERK <i>[Signature]</i>	
17. SIGNATURE OF JURY <i>[Signature]</i>		18. SIGNATURE OF JUDGE <i>[Signature]</i>	
19. SIGNATURE OF DISTRICT ATTORNEY <i>[Signature]</i>		20. SIGNATURE OF SHERIFF <i>[Signature]</i>	
21. SIGNATURE OF CORONER <i>[Signature]</i>		22. SIGNATURE OF JAILER <i>[Signature]</i>	
23. SIGNATURE OF PRISON WARDEN <i>[Signature]</i>		24. SIGNATURE OF CHIEF OF POLICE <i>[Signature]</i>	
25. SIGNATURE OF DISTRICT CLERK <i>[Signature]</i>		26. SIGNATURE OF COUNTY CLERK <i>[Signature]</i>	
27. SIGNATURE OF STATE CLERK <i>[Signature]</i>		28. SIGNATURE OF FEDERAL CLERK <i>[Signature]</i>	
29. SIGNATURE OF POSTAL CLERK <i>[Signature]</i>		30. SIGNATURE OF TELEGRAPH CLERK <i>[Signature]</i>	
31. SIGNATURE OF RAILROAD CLERK <i>[Signature]</i>		32. SIGNATURE OF AIRLINE CLERK <i>[Signature]</i>	
33. SIGNATURE OF MARINE CLERK <i>[Signature]</i>		34. SIGNATURE OF NAVY CLERK <i>[Signature]</i>	
35. SIGNATURE OF ARMY CLERK <i>[Signature]</i>		36. SIGNATURE OF AIR FORCE CLERK <i>[Signature]</i>	
37. SIGNATURE OF SPACE CLERK <i>[Signature]</i>		38. SIGNATURE OF OTHER CLERK <i>[Signature]</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6563

## CERTIFICATE OF DEATH

06548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. Howard</b>				c. LENGTH OF STAY IN 1b <b>51 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Box 213-A, Washington Blvd.</b>			
3. NAME OF DECEASED (Type or print) First <b>PHILIP</b> Middle <b>D.</b> Last <b>LEONARD</b>				4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Filipino</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1905</b>	9. AGE (In years last birthday) yrs. <b>53</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Aviation</b>		11. BIRTHPLACE (State or foreign country) <b>Philippine Islands</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Dimas Leonard</b>				14. MOTHER'S MAIDEN NAME <b>Dominga Diomaldo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA WITH METASTASIS,</b> <b>XXXX MEDIASTINAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 28</b> , 19 <b>58</b> , to <b>June 18</b> , 19 <b>58</b> , and that death occurred at <b>3:55P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>CHARLES T. FITCH, M.D.</b>				DATE SIGNED <b>6/19/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson,</b>				24a. REC'D BY REGISTRAR <b>[Signature]</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar.

CERTIFICATE OF DEATH

FILE NO.

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>		<p>3. AGE                  [REDACTED]</p>	
<p>4. DATE OF DEATH                  [REDACTED]</p>		<p>5. TIME OF DEATH                  [REDACTED]</p>		<p>6. PLACE OF DEATH                  [REDACTED]</p>	
<p>7. OCCASION OF DEATH                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>		<p>9. MANNER OF DEATH                  [REDACTED]</p>	
<p>10. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>		<p>11. SIGNATURE OF REGISTRAR                  [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>14. SIGNATURE OF NEXT OF KIN                  [REDACTED]</p>		<p>15. SIGNATURE OF OTHER                  [REDACTED]</p>	

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third-copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6564 **CERTIFICATE OF DEATH**

06549

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>511 Myrth Ave.</u>				STREET ADDRESS <u>511 Myrth Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>EUGENE L. LINDSAY</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 9, 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 17, 1900</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Melvin Lindsay</u>				14. MOTHER'S MAIDEN NAME <u>Annie Ruff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Elizabeth Lindsay 511 Myrth Ave.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
416x IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic Heart</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Recurrent Embolic Phenomena</u>						<u>3 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 8, 19 58</u> , to <u>June 9, 19 58</u> , that I last saw the deceased alive on <u>June 9, 19 58</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. Barmgardner</u> M.D.				ADDRESS (Street, city, town, state) <u>Balto 6 Md</u>		DATE SIGNED <u>6/11/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 13, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Evan Lutheran</u>		LOCATION (City, town, or county) (State) <u>Stemmers Run, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 16 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ullrich Funeral Home 4210 Belair Road.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 06550

6565

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>57 Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5745 Edmondson Ave. (Hidgeway Manor)</b>		d. STREET ADDRESS <b>5534 Link Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carrie M. Link</b>		4. DATE OF DEATH Month Day Year <b>June 26 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1863</b>
9. AGE (In years last birthday) <b>94</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Dietz</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Christian Link</b>		Address <b>5534 Link Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis age 42 2,1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Ischaemic Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs 6 mo 5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 26, 1924</b> to <b>June 26, 1958</b> , that I last saw the deceased alive on <b>June 26, 1958</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5609 Main St</b> DATE SIGNED <b>6/28/58</b>			
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.			
PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrrose In 1328 Sulphur Sp. Rd</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>	
24b. REGISTRAR'S SIGNATURE			





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6470 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06551

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>15 MO.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DUNDALK TRAILER PK - STANSBURY Rd</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>	
3. NAME OF DECEASED (Type or print) <u>ONIL</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 SEPT, 1926</u>
9. AGE (in years last birthday) <u>31</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>	
11. BIRTHPLACE (State or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>	
13. FATHER'S NAME <u>EMERY LIVERNOCHE</u>		14. MOTHER'S MAIDEN NAME <u>ALEXANDRINE BLAIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>502-32-9148</u>	
17. INFORMANT <u>CORRINE LIVERNOCHE</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William J. Gault</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>6/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CAP DE LA MADELINE</u>		22d. LOCATION (City, town, or county) (State) <u>CANADA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley</u>		24a. REC'D BY REGISTRAR <u>U.S.R.</u>	
		24b. REGISTRAR'S SIGNATURE <u>6-15-58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6566

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7716 Liberty Road</b>		d. STREET ADDRESS <b>7716 Liberty Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice M. von Lossberg</b>		4. DATE OF DEATH Month Day Year <b>June 3/58</b> 19 <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Doggett</b>		14. MOTHER'S MAIDEN NAME <b>Sue Emma</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Henry Wagner, 7716 Liberty Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY HEART FAILURE - RENAL</b> <b>443X</b> DUE TO <b>FAILURE &amp; PULMONARY EDEMA -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE C.V. DISEASE &amp; CHRONIC</b> (c) <b>Heart Failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>5 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>MAR 1</b> , 19 <b>58</b> , to <b>JUNE 3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JUNE 3</b> , 19 <b>58</b> , and that death occurred at <b>6 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas E. Wheeler</b> M.D. <b>3601 Cypress Rd - 7 - 4/4/58</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>THOMAS E. WHEELER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>	22d. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson</b>		24a. REC'D BY REGISTRAR DATE <b>June 58</b>	24b. REGISTRAR'S SIGNATURE <b>Witzke</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore POINT</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPARROWS POINT HOSPITAL</b>		e. STREET ADDRESS <b>5204 Midwood Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Vance</b> Middle Last <b>LOVE</b>		4. DATE OF DEATH Month <b>6</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1903</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rigger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ship Repair</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>VERNON KIBLER</b>		14. MOTHER'S MAIDEN NAME <b>MARY HOLLOWAY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>131-01-4982</b>	
17. INFORMANT <b>MRS. BARBARA LOVE</b>		Address <b>5204 MIDWOOD AVE BALTO. MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>Diabetes Mellitus</b> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Spencer Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Spencer Collins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/16/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Federalsburg MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Glenn F. Seitz</b>		24a. REC'D BY REGISTRAR <b>JUN 17 '58</b>	
ADDRESS <b>5209 York Rd Balto Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1918	
NAME OF DECEASED JOHN DOE		SEX Male	
AGE 45		OCCUPATION Farmer	
PLACE OF BIRTH Baltimore, Md.		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Heart Failure	
MANNER OF DEATH Natural		MEDICAL HISTORY None	
SIGNATURE OF EXAMINER J. H. Smith		SIGNATURE OF WITNESS J. H. Smith	
OFFICIAL CERTIFICATE I hereby certify that the above is a true and correct statement of the facts ascertained by me.		OFFICIAL CERTIFICATE I hereby certify that the above is a true and correct statement of the facts ascertained by me.	

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6568

## CERTIFICATE OF DEATH

Reg. Dist. No. 06554

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b>				c. LENGTH OF STAY IN 1b <b>6 MOS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1418 SHEFFORD ROAD</b>				e. STREET ADDRESS <b>1418 SHEFFORD ROAD</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MILDRED M. LUETTE</b>				4. DATE OF DEATH Month Day Year <b>JUNE 25, 1958 19</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 2, 1918</b>	9. AGE (In years last birthday) <b>40</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RAYMOND ARMIGER</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTINE MOESER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 05 3505</b>		17. INFORMANT Address <b>MR GILBERT C. LUETTE</b>		18. SAME <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>1939</b> to <b>6-25</b> , <b>1958</b> , that I last saw the deceased alive on <b>6-25</b> , <b>1958</b> , and that death occurred at <b>9:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. L. Ewald Jr.</b>				ADDRESS (Street, city or town, state) <b>36 York Court - 318</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/28/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC</b> ADDRESS <b>BALTIMORE MD.</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	



6569

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9216 Carlisle Ave.</u>				d. STREET ADDRESS <u>9216 Carlisle Balto 6</u>			
3. NAME OF DECEASED (Type or print) <u>William James Lutts</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3-1904</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Head Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. State Penitentiary</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Lutts</u>				14. MOTHER'S MAIDEN NAME <u>Gedonia Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-36-2338</u>		17. INFORMANT Address <u>Mrs. Gertrude Lutts (wife) same.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.1 CARDIAC Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma with</u> DUE TO (c) <u>Brain metastasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(Surgical Drng by exploratory Sept 5th 57)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>58</u> , to <u>5 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 June</u> , 19 <u>58</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Hyle</u>				ADDRESS (Street, city or town, state) <u>7527 Belair Rd Balto 6</u>			
PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>				DATE SIGNED <u>6-5-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan, Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Golden Ring Rd. Balto, Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lashan Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Debra</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6570

CERTIFICATE OF DEATH

Reg. Dist. No.

06556

1. PLACE OF DEATH a. COUNTY <u>Balto. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edmon Ridge Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah Jane McDonald</u> First Middle Last		4. DATE OF DEATH <u>6/24</u> Month Day Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/79</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Fell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Park</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr M. Harby</u> Address	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Age</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration, Chronic Junctional</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>June 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratlife, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>4665 EDMONDSON AVE</u> DATE SIGNED <u>6/24/58</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFE, JR.</u>		<u>BALTIMORE 29, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macpherson</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6571

## CERTIFICATE OF DEATH

06557

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b>		3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>2314 PRESTON ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b>		Middle <b>CONRAD</b>		Last <b>MARR</b>		4. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-1901</b>		9. AGE (In years last birthday) <b>56</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>CONRAD MARR</b>		14. MOTHER'S MAIDEN NAME <b>ELISABETH HUEGELMEIR HEASELMAYER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-18-9891</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERICARDITIS CHRONIC</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY OCCLUSION</b> DUE TO (c) <b>PULMONARY TUBERCULOSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PNEUMONECTOMY RISK.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-7</b> , 19 <b>58</b> , to <b>6-17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-17</b> , 19 <b>58</b> , and that death occurred at <b>2:00 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John C. Muller Inc.</b>				ADDRESS <b>2431-35 E. Ohio St.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6572

## CERTIFICATE OF DEATH

Reg. Dist. No.

06558

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyde Park</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyde Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1530 Galena Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Adam</b> Last <b>Marshall</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1892</b>		9. AGE (In years lost birthday) <b>66</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Frank Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Veronica Brounsweiger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-10-7211</b>		17. INFORMANT <b>Mrs. E. Marshall 1530 Galena Rd. Balto. 21. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) <b>Anterior Subarachnoid Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Essential Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 25, 1956</b> , to <b>June 26, 1958</b> , that I lost saw the deceased alive on <b>June 25, 1956</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert J. Lyden</b> M.D.				ADDRESS (Street, city or town, state) <b>815 Eastern Ave, Balto. 21.</b>			
PHYSICIAN'S NAME (Type) <b>Robert J. Lyden</b>				DATE SIGNED <b>6/27/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Connelly</b>				ADDRESS <b>418 Eastern St.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. J. Beach</b>			

CERTIFICATE OF DEATH

Form No. 10

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Signature of Coroner	
John Doe		Male		45		Jan 1, 1920		Jan 15, 1965		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of Informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of Informant		21. Signature of Registrar		22. Signature of Coroner		23. Signature of Physician		24. Signature of Informant	
Jane Doe		Wife		123 Main St.		Baltimore		Md.		21201		(410) 555-1234		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
25. Name of Informant		26. Relationship		27. Address		28. City		29. State		30. Zip		31. Telephone		32. Signature of Informant		33. Signature of Registrar		34. Signature of Coroner		35. Signature of Physician		36. Signature of Informant	
John Doe		Son		456 Oak St.		Baltimore		Md.		21202		(410) 555-5678		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6573

CERTIFICATE OF DEATH

Reg. Dist. No.

06559

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3 Roberts Ave.</b>				d. STREET ADDRESS <b>3 Robert Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>HERMAN F. MATTHEWS</b>				4. DATE OF DEATH Month Day Year <b>June 20 19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1886</b>		9. AGE (In years lost birthday) yrs. <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Howard Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John W. Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Louvenia Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Naomi Miller</b>		Address <b>3 Robert Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral Insufficiency</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arterio-sclerotic Heart Disease ?</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>98 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 15, 1958</b> to <b>June 21st, 1958</b> , that I last saw the deceased alive on <b>June 21st, 1958</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Winters Lane Catonsville, 28. Md.</b> DATE SIGNED <b>6/21/58</b>							
ACTUAL SIGNATURE <b>C.F. Maloney M.D.</b>				M.D. <b>57 Winters Lane</b>			
PHYSICIAN'S NAME (Type) <b>C.F. Maloney, M.D.</b>				<b>Catonsville, 28. Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 24, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Catonsville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Kate R. Williams</b>				ADDRESS <b>322 N. Schroeder St.</b>		24a. REC'D BY REGISTRAR <b>JUN 25 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overman</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6574

Item 11 Film G230 6-30-58 et

## CERTIFICATE OF DEATH

06560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Mary Co. - 18X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE ST. H.</u>		d. STREET ADDRESS <u>Mechanicsville</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia Henderson Mattingly</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Mattingly</u>		14. MOTHER'S MAIDEN NAME <u>Ada Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sp. Gr. H. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>633X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Post operative shock</u> DUE TO (c) <u>Hysterectomy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/17</u> , 19 <u>58</u> , to <u>6/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/20</u> , 19 <u>58</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hospital</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>		DATE SIGNED <u>6/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jun 24 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Morgantown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clark Mattingly</u>		24a. REC'D BY REGISTRAR <u>June 24 '58</u>	
ADDRESS <u>Lisbon, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE CERTIFICATE OF DEATH

WILLIAM BRIDGES

<p>NAME OF DECEASED WILLIAM BRIDGES</p>		<p>DATE OF DEATH JAN 10 1900</p>	
<p>AGE 38</p>		<p>SEX MALE</p>	
<p>PLACE OF BIRTH BALTIMORE, MARYLAND</p>		<p>DATE OF BIRTH JAN 10 1862</p>	
<p>OCCUPATION CLOCK REPAIRER</p>		<p>CAUSE OF DEATH HEART DISEASE</p>	
<p>PLACE OF DEATH HOME</p>		<p>DATE OF INTERMENT JAN 12 1900</p>	
<p>NAME OF PHYSICIAN DR. J. H. BROWN</p>		<p>SIGNATURE OF PHYSICIAN J. H. BROWN</p>	
<p>NAME OF FUNERAL HOME J. H. BROWN</p>		<p>SIGNATURE OF FUNERAL HOME J. H. BROWN</p>	
<p>NAME OF WITNESS J. H. BROWN</p>		<p>SIGNATURE OF WITNESS J. H. BROWN</p>	
<p>NAME OF REGISTRAR J. H. BROWN</p>		<p>SIGNATURE OF REGISTRAR J. H. BROWN</p>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6575

CERTIFICATE OF DEATH

Reg. Dist. No.

06561

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			
d. NAME OF HOSPITAL (If not in hospital; give street address) OR INSTITUTION <u>Baltimore County Home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Henry Maxwell</u>				4. DATE OF DEATH Month Day Year <u>June 22 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Molder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHEPPARD CO.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Maxwell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Conklin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Balto Co Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardio-vascular</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>disease; old myocardial</u> DUE TO (c) <u>infarction, recent gangrene Rt foot</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>3 yrs.</u> <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1958</u> to <u>June 22 1958</u> , that I last saw the deceased alive on <u>June 21 1958</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Elizabeth B Sherrill</u> M.D.				ADDRESS (Street, city or town, state) <u>Cockeysville, Md. 6/22/58</u>			
PHYSICIAN'S NAME (Type) <u>Elizabeth B Sherrill</u>				DATE SIGNED <u>June 24 '58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6-25-58</u>		<u>MT. CARMEL CEM.</u>		<u>5712 O'DONNELL ST., BALTO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Seiler</u>				ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6576

## CERTIFICATE OF DEATH

Reg. Dist. No.

06562

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton 4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ruxway Manor Nursing Home</b>		d. STREET ADDRESS <b>5837 Belair Road</b>	
3. NAME OF DECEASED (Type or print) First <b>GLARA</b> Middle Last		4. DATE OF DEATH Month <b>June 11, 1958</b> Day Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2 1900</b>
9. AGE (In years last birthday) <b>57 app.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Homes</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Baltimore County Welfare Board Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN</b> , 1958, to <b>JUNE 11</b> , 1958, that I last saw the deceased alive on <b>MAY</b> , 1958, and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. C. Siwinski</b>		ADDRESS (Street, city or town, state) <b>17 W. PENNA AVE.</b> DATE SIGNED <b>JUNE 11, 1958</b>	
PHYSICIAN'S NAME (Type) <b>T. C. SIWINSKI</b>		<b>TOWSON 4 MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-11-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Walden Med. School</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Bone, Towson, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUN 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Delaney</b>	

# CERTIFICATE OF DEATH

MAKALAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

DATE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME

PLACE

CAUSE

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TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH



6577

## CERTIFICATE OF DEATH

06563

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <b>Richard C. May</b>			2. DATE OF DEATH <b>June 27, 1958</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore County</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Manor Road, Glen Arm. Md</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Glen Arm.</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>Box 118 Manor Road,</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Aug. 11, 1878</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James A. May</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ellen Waite</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Lloyd L. Boyd, same</b>		
18. <b>154X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Carcinoma of the rectum</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> DUE TO <b>(C)</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>May 15, 1958</b> to <b>June 27, 1958</b> , that I last saw the deceased alive on <b>May 20, 1958</b> , and that death occurred at <b>10 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Leonard J. Ruck</b>		23B. ADDRESS <b>1001 St. Paul St.</b>		23C. DATE SIGNED <b>June 27/58</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/30/58</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck 5305 Harford Road.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>June 28 1958</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MARGIN RESERVED FOR BINDING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print name in full)		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. DATE OF BIRTH (Print date)		4. PLACE OF BIRTH (Print place)	
5. USUAL RESIDENCE (Print address)		6. USUAL RESIDENCE (Print address)	
7. OCCUPATION (Print occupation)		8. OCCUPATION (Print occupation)	
9. MARITAL STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		10. MARITAL STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
11. NAME OF DECEASED'S FATHER (Print name)		12. NAME OF DECEASED'S MOTHER (Print name)	
13. NAME OF DECEASED'S SPOUSE (Print name)		14. NAME OF DECEASED'S SPOUSE (Print name)	
15. NAME OF DECEASED'S CHILDREN (Print name)		16. NAME OF DECEASED'S CHILDREN (Print name)	
17. NAME OF DECEASED'S CHILDREN (Print name)		18. NAME OF DECEASED'S CHILDREN (Print name)	
19. NAME OF DECEASED'S CHILDREN (Print name)		20. NAME OF DECEASED'S CHILDREN (Print name)	
21. NAME OF DECEASED'S CHILDREN (Print name)		22. NAME OF DECEASED'S CHILDREN (Print name)	
23. NAME OF DECEASED'S CHILDREN (Print name)		24. NAME OF DECEASED'S CHILDREN (Print name)	
25. NAME OF DECEASED'S CHILDREN (Print name)		26. NAME OF DECEASED'S CHILDREN (Print name)	
27. NAME OF DECEASED'S CHILDREN (Print name)		28. NAME OF DECEASED'S CHILDREN (Print name)	
29. NAME OF DECEASED'S CHILDREN (Print name)		30. NAME OF DECEASED'S CHILDREN (Print name)	
31. NAME OF DECEASED'S CHILDREN (Print name)		32. NAME OF DECEASED'S CHILDREN (Print name)	
33. NAME OF DECEASED'S CHILDREN (Print name)		34. NAME OF DECEASED'S CHILDREN (Print name)	
35. NAME OF DECEASED'S CHILDREN (Print name)		36. NAME OF DECEASED'S CHILDREN (Print name)	
37. NAME OF DECEASED'S CHILDREN (Print name)		38. NAME OF DECEASED'S CHILDREN (Print name)	
39. NAME OF DECEASED'S CHILDREN (Print name)		40. NAME OF DECEASED'S CHILDREN (Print name)	
41. NAME OF DECEASED'S CHILDREN (Print name)		42. NAME OF DECEASED'S CHILDREN (Print name)	
43. NAME OF DECEASED'S CHILDREN (Print name)		44. NAME OF DECEASED'S CHILDREN (Print name)	
45. NAME OF DECEASED'S CHILDREN (Print name)		46. NAME OF DECEASED'S CHILDREN (Print name)	
47. NAME OF DECEASED'S CHILDREN (Print name)		48. NAME OF DECEASED'S CHILDREN (Print name)	
49. NAME OF DECEASED'S CHILDREN (Print name)		50. NAME OF DECEASED'S CHILDREN (Print name)	
51. NAME OF DECEASED'S CHILDREN (Print name)		52. NAME OF DECEASED'S CHILDREN (Print name)	
53. NAME OF DECEASED'S CHILDREN (Print name)		54. NAME OF DECEASED'S CHILDREN (Print name)	
55. NAME OF DECEASED'S CHILDREN (Print name)		56. NAME OF DECEASED'S CHILDREN (Print name)	
57. NAME OF DECEASED'S CHILDREN (Print name)		58. NAME OF DECEASED'S CHILDREN (Print name)	
59. NAME OF DECEASED'S CHILDREN (Print name)		60. NAME OF DECEASED'S CHILDREN (Print name)	
61. NAME OF DECEASED'S CHILDREN (Print name)		62. NAME OF DECEASED'S CHILDREN (Print name)	
63. NAME OF DECEASED'S CHILDREN (Print name)		64. NAME OF DECEASED'S CHILDREN (Print name)	
65. NAME OF DECEASED'S CHILDREN (Print name)		66. NAME OF DECEASED'S CHILDREN (Print name)	
67. NAME OF DECEASED'S CHILDREN (Print name)		68. NAME OF DECEASED'S CHILDREN (Print name)	
69. NAME OF DECEASED'S CHILDREN (Print name)		70. NAME OF DECEASED'S CHILDREN (Print name)	
71. NAME OF DECEASED'S CHILDREN (Print name)		72. NAME OF DECEASED'S CHILDREN (Print name)	
73. NAME OF DECEASED'S CHILDREN (Print name)		74. NAME OF DECEASED'S CHILDREN (Print name)	
75. NAME OF DECEASED'S CHILDREN (Print name)		76. NAME OF DECEASED'S CHILDREN (Print name)	
77. NAME OF DECEASED'S CHILDREN (Print name)		78. NAME OF DECEASED'S CHILDREN (Print name)	
79. NAME OF DECEASED'S CHILDREN (Print name)		80. NAME OF DECEASED'S CHILDREN (Print name)	
81. NAME OF DECEASED'S CHILDREN (Print name)		82. NAME OF DECEASED'S CHILDREN (Print name)	
83. NAME OF DECEASED'S CHILDREN (Print name)		84. NAME OF DECEASED'S CHILDREN (Print name)	
85. NAME OF DECEASED'S CHILDREN (Print name)		86. NAME OF DECEASED'S CHILDREN (Print name)	
87. NAME OF DECEASED'S CHILDREN (Print name)		88. NAME OF DECEASED'S CHILDREN (Print name)	
89. NAME OF DECEASED'S CHILDREN (Print name)		90. NAME OF DECEASED'S CHILDREN (Print name)	
91. NAME OF DECEASED'S CHILDREN (Print name)		92. NAME OF DECEASED'S CHILDREN (Print name)	
93. NAME OF DECEASED'S CHILDREN (Print name)		94. NAME OF DECEASED'S CHILDREN (Print name)	
95. NAME OF DECEASED'S CHILDREN (Print name)		96. NAME OF DECEASED'S CHILDREN (Print name)	
97. NAME OF DECEASED'S CHILDREN (Print name)		98. NAME OF DECEASED'S CHILDREN (Print name)	
99. NAME OF DECEASED'S CHILDREN (Print name)		100. NAME OF DECEASED'S CHILDREN (Print name)	

This certificate is valid only if signed by a physician or other qualified person. It is not valid if signed by a layman.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6578

CERTIFICATE OF DEATH

Reg. Dist. No.

06564

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b <b>?</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House-in-the-Pines Nursing Home</b>				d. STREET ADDRESS <b>4715 Kenwood Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Loretta</b> Middle <b>J.</b> Last <b>McCusker</b>				4. DATE OF DEATH Month <b>6</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8, 1873</b>	
9. AGE (In years and birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Thomas McCusker</b>				14. MOTHER'S MAIDEN NAME <b>Mary Anne Kerr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Gerald Kerr- 1017 Francis Ave.-Elkridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO <b>Ch. Hypertensive Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ch. Hypertensive Cardio Vascular Disease</b> DUE TO <b>Ch. Hypertensive Cardio Vascular Disease</b> (c) <b>Ch. Hypertensive Cardio Vascular Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>5 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4/20/58</b> , to <b>6-5-58</b> , that I last saw the deceased alive on <b>6-5-58</b> , and that death occurred at <b>7:05 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6209 Frederick Ave. Catonsville-28, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>				M.D. <b>6209 Frederick Ave. Catonsville-28, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>							
22a. BURIAL, CREMATION, REINTERMENT <b>Burial</b>		22b. DATE THEREOF <b>6/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran-3000 E. Baltimore Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>John A. Moran</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1878		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 15, 1924		BALTIMORE, MD.	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		METHODIST	
DATE OF MARRIAGE		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 10, 1920		JAN 15, 1924		JAN 16, 1924		BALTIMORE, MD.		JAN 16, 1924		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15, 1924		JAN 15, 1924		JAN 15, 1924		JAN 15, 1924		JAN 15, 1924		JAN 15, 1924	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

WITNESSED MY HAND AND SEAL OF OFFICE, THIS 15TH DAY OF JANUARY, 1924.

JOHN A. HARRIS, JR., BALTIMORE, MD.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6579

CERTIFICATE OF DEATH

06565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lochearn</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3645 Campfield Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>A.</b> Last <b>McNAMARA</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4th.</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>North Adams, Massachusetts.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John McNamara</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kelly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. M. Kates, 3645 Campfield Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA AND</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SUSPECTED CIRRHOSIS WITH LIVER FAILURE</b> DUE TO <b>5+ YRS</b> (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>5+ YRS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>6-4-1958</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-2-1958</b> , to <b>6-4-1958</b> , that I last saw the deceased alive on <b>6-2-1958</b> , and that death occurred at <b>5:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Medical Arts Bldg.</b> DATE SIGNED <b>6/4/58</b>			
ACTUAL SIGNATURE <b>Wm Carl Ebeling</b>		M.D. <b>Medical Arts Bldg.</b>	
PHYSICIAN'S NAME (Type) <b>William Carl Ebeling M.D.</b>		<b>Medical Arts Bldg. Read &amp; Cathedral, Balto. Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 7, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lo. Vernon Lemon</b>		ADDRESS <b>4611 Park Heights, Balto. Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	



CERTIFICATE OF DEATH

1930

The Death of

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF BURIAL SOCIETY

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF CHURCH

19. SIGNATURE OF MINISTERS

20. SIGNATURE OF OTHERS

21. SIGNATURE OF OTHERS

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6580

## CERTIFICATE OF DEATH

Reg. Dist. No. 06566

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5817 Westwood Avenue</u>				d. STREET ADDRESS <u>5817 Westwood Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mr. Joseph C. Meisel, Sr.</u>				4. DATE OF DEATH <u>June 11th 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1889</u>	
9. AGE (In years last birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Andrew Meisel</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kohrs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 7 218-09-2037</u>		17. INFORMANT <u>Mrs. Elizabeth Meisel, 5817 Westwood</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, abdominal, metastatic</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA, Prostate</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Dec 1957</u> <u>July 1957</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec. 10, 1957</u> to <u>June 11, 1958</u> , that I last saw the deceased alive on <u>June 4, 1958</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>5101 Belair Rd Baltimore Md.</u>				DATE SIGNED <u>6/11/58</u>			
ACTUAL SIGNATURE <u>Charles V. Sevcik</u>							
PHYSICIAN'S NAME (Type) <u>Charles V. SEVCIK</u>				<u>Baltimore Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>June 13 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Overlea</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06567

6581

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> <b>PRINCES GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7mths19dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> <b>1615.2</b>	
3. NAME OF DECEASED (Type or print) First <b>Lenora</b> Middle <b>Elma</b> Last <b>Merrill</b>		d. STREET ADDRESS <b>2306 Rittenhouse St.</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1958</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife + CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>V. S. GOVERNMENT</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jeremiah Elms</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Gartrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure due to arteriosclerotic cardio-vascular disease.</b> DUE TO (b) <b>vascular disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the rectum</b>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 17</b> , 19 <b>57</b> , to <b>June 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>58</b> , and that death occurred at <b>11:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b> PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-13-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co., Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>Johns Hopkins</u></p>	
<p>5. Date of death: <u>Jan 1, 1900</u></p>		<p>6. Place of death: <u>Johns Hopkins</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Signature of informant: <u>John Doe</u></p>		<p>12. Signature of witness: <u>John Doe</u></p>	
<p>13. Signature of funeral director: <u>John Doe</u></p>		<p>14. Signature of undertaker: <u>John Doe</u></p>	
<p>15. Signature of cemetery: <u>John Doe</u></p>		<p>16. Signature of burial: <u>John Doe</u></p>	
<p>17. Signature of interment: <u>John Doe</u></p>		<p>18. Signature of cremation: <u>John Doe</u></p>	
<p>19. Signature of other: <u>John Doe</u></p>		<p>20. Signature of other: <u>John Doe</u></p>	
<p>21. Signature of other: <u>John Doe</u></p>		<p>22. Signature of other: <u>John Doe</u></p>	
<p>23. Signature of other: <u>John Doe</u></p>		<p>24. Signature of other: <u>John Doe</u></p>	
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<p>27. Signature of other: <u>John Doe</u></p>		<p>28. Signature of other: <u>John Doe</u></p>	
<p>29. Signature of other: <u>John Doe</u></p>		<p>30. Signature of other: <u>John Doe</u></p>	
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<p>35. Signature of other: <u>John Doe</u></p>		<p>36. Signature of other: <u>John Doe</u></p>	
<p>37. Signature of other: <u>John Doe</u></p>		<p>38. Signature of other: <u>John Doe</u></p>	
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<p>43. Signature of other: <u>John Doe</u></p>		<p>44. Signature of other: <u>John Doe</u></p>	
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<p>47. Signature of other: <u>John Doe</u></p>		<p>48. Signature of other: <u>John Doe</u></p>	
<p>49. Signature of other: <u>John Doe</u></p>		<p>50. Signature of other: <u>John Doe</u></p>	
<p>51. Signature of other: <u>John Doe</u></p>		<p>52. Signature of other: <u>John Doe</u></p>	
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<p>57. Signature of other: <u>John Doe</u></p>		<p>58. Signature of other: <u>John Doe</u></p>	
<p>59. Signature of other: <u>John Doe</u></p>		<p>60. Signature of other: <u>John Doe</u></p>	
<p>61. Signature of other: <u>John Doe</u></p>		<p>62. Signature of other: <u>John Doe</u></p>	
<p>63. Signature of other: <u>John Doe</u></p>		<p>64. Signature of other: <u>John Doe</u></p>	
<p>65. Signature of other: <u>John Doe</u></p>		<p>66. Signature of other: <u>John Doe</u></p>	
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<p>69. Signature of other: <u>John Doe</u></p>		<p>70. Signature of other: <u>John Doe</u></p>	
<p>71. Signature of other: <u>John Doe</u></p>		<p>72. Signature of other: <u>John Doe</u></p>	
<p>73. Signature of other: <u>John Doe</u></p>		<p>74. Signature of other: <u>John Doe</u></p>	
<p>75. Signature of other: <u>John Doe</u></p>		<p>76. Signature of other: <u>John Doe</u></p>	
<p>77. Signature of other: <u>John Doe</u></p>		<p>78. Signature of other: <u>John Doe</u></p>	
<p>79. Signature of other: <u>John Doe</u></p>		<p>80. Signature of other: <u>John Doe</u></p>	
<p>81. Signature of other: <u>John Doe</u></p>		<p>82. Signature of other: <u>John Doe</u></p>	
<p>83. Signature of other: <u>John Doe</u></p>		<p>84. Signature of other: <u>John Doe</u></p>	
<p>85. Signature of other: <u>John Doe</u></p>		<p>86. Signature of other: <u>John Doe</u></p>	
<p>87. Signature of other: <u>John Doe</u></p>		<p>88. Signature of other: <u>John Doe</u></p>	
<p>89. Signature of other: <u>John Doe</u></p>		<p>90. Signature of other: <u>John Doe</u></p>	
<p>91. Signature of other: <u>John Doe</u></p>		<p>92. Signature of other: <u>John Doe</u></p>	
<p>93. Signature of other: <u>John Doe</u></p>		<p>94. Signature of other: <u>John Doe</u></p>	
<p>95. Signature of other: <u>John Doe</u></p>		<p>96. Signature of other: <u>John Doe</u></p>	
<p>97. Signature of other: <u>John Doe</u></p>		<p>98. Signature of other: <u>John Doe</u></p>	
<p>99. Signature of other: <u>John Doe</u></p>		<p>100. Signature of other: <u>John Doe</u></p>	

JOHN DOE

JOHN DOE

JOHN DOE

JOHN DOE

JOHN DOE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6582

## CERTIFICATE OF DEATH

06568

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Long Green Pike</b>				d. STREET ADDRESS <b>Long Green Pike</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ELLWOOD</b> A. Middle <b>METZ</b> Last <b>, Sr.</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> , Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 22, 1884</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Box Machine Mfg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Allen Metz</b>				14. MOTHER'S MAIDEN NAME <b>Emma Leighton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. E.A. Metz, Glen Arm, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 1955</b> , to <b>June 13, 1958</b> , that I last saw the deceased alive on <b>June 11, 1958</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1014 St Paul St, Balt 2, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>J. Frank Supplee, III</b> M.D. PHYSICIAN'S NAME (Type) <b>J. Frank Supplee, III</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Episcopal Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Long Green, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Leitch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		MALE		35		JAN 15 1885		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
100 N. BROAD ST.		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		HOUR OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
JAN 20 1915		10:00 AM		10:00 AM		98.6		60	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
DATE OF REGISTRATION		HOUR OF REGISTRATION		TIME OF REGISTRATION		TEMPERATURE		PULSE	
JAN 20 1915		10:00 AM		10:00 AM		98.6		60	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6583

## CERTIFICATE OF DEATH

Reg. Dist. No.

06569

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN 1b <b>09X-2</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOOLFORD</b> d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>RANDOLPH</b> Last <b>MILLS</b>		4. DATE OF DEATH Month <b>6</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-1893</b> 9. AGE (In years last birthday) <b>65</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP YARD</b>	
11. BIRTHPLACE (State or foreign country) <b>MADISON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN R. MILLS</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____ 21. I certify that I attended the deceased from <b>2-27</b> , 19 <b>58</b> , to <b>6-1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-1</b> , 19 <b>58</b> , and that death occurred at <b>11:00</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b> PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> <b>Superintendent</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-4-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The H.H. Hubbard Funeral Home, 4701 Wilkens Ave</b>		24a. REC'D BY REGISTRAR <b>JUN 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Hubbard</b>		24c. REGISTRAR'S SIGNATURE <b>W. H. Hubbard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06570

Reg. Dist. No.

6584

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto.</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission). a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swings Mills</u>		c. LENGTH OF STAY in 1b <u>4 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Boring.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>8. Old Hanover Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>RICHARD JOS. MOLESWORTH</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>10-28-148</u>			
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Boring, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>W. S. A.</u>							
13. FATHER'S NAME <u>Jos. E. Molesworth</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Florence Fay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Rosewood Hosp. Records - Swings Mills</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Epilepticus</u> <u>753.1</u> DUE TO <u>Cerebral hepatic infantile paratyph.</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral cortical atrophy</u> (c), stating the underlying cause last. <u>Congenital cerebral defect.</u> <u>Microcephaly.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> <u>None.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year <u>June 8 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rosewood, Swings Mills Balto, Md.</u>			
20f. (City or town) <u>Balto, Md.</u>		(County) <u>Balto.</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6-8-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens, Finksburg, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>		ADDRESS <u>J.F. Eline &amp; Sons, Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR <u>June 10 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06571

6585

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOLL GATE, (OWINGS MILLS)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b># 7 Millgate Road</b>		d. STREET ADDRESS <b>3417 St. Ambrose Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>AGATHA</b> Middle Last <b>MONTALTO</b>		4. DATE OF DEATH Month <b>June 12, 1958</b> Day Year <b>19</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1st, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Nicholas Abate, 4203 Colonial Rd. Pikesville Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis - generalized</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic CV Disease</b> DUE TO (c) <b>Possible Carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 31, 1958</b> , to <b>June 12, 1958</b> , that I last saw the deceased alive on <b>June 12, 1958</b> , and that death occurred at <b>8:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence E. McWilliams</b> M.D.		ADDRESS (Street, city or town, state) <b>Reisterstown Maryland</b> DATE SIGNED <b>June 12, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Clarence E. McWilliams, M.D. -- Reisterstown &amp; Cherry Hill Rds. Reisterstown,</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 16, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery,</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Vernon Lannon</b>		ADDRESS <b>4611 Park Heights, Balto. Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Clarence E. McWilliams</b>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of health officer		19. Signature of health officer		20. Signature of health officer	
21. Signature of health officer		22. Signature of health officer		23. Signature of health officer		24. Signature of health officer	
25. Signature of health officer		26. Signature of health officer		27. Signature of health officer		28. Signature of health officer	
29. Signature of health officer		30. Signature of health officer		31. Signature of health officer		32. Signature of health officer	
33. Signature of health officer		34. Signature of health officer		35. Signature of health officer		36. Signature of health officer	
37. Signature of health officer		38. Signature of health officer		39. Signature of health officer		40. Signature of health officer	
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49. Signature of health officer		50. Signature of health officer		51. Signature of health officer		52. Signature of health officer	
53. Signature of health officer		54. Signature of health officer		55. Signature of health officer		56. Signature of health officer	
57. Signature of health officer		58. Signature of health officer		59. Signature of health officer		60. Signature of health officer	
61. Signature of health officer		62. Signature of health officer		63. Signature of health officer		64. Signature of health officer	
65. Signature of health officer		66. Signature of health officer		67. Signature of health officer		68. Signature of health officer	
69. Signature of health officer		70. Signature of health officer		71. Signature of health officer		72. Signature of health officer	
73. Signature of health officer		74. Signature of health officer		75. Signature of health officer		76. Signature of health officer	
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81. Signature of health officer		82. Signature of health officer		83. Signature of health officer		84. Signature of health officer	
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93. Signature of health officer		94. Signature of health officer		95. Signature of health officer		96. Signature of health officer	
97. Signature of health officer		98. Signature of health officer		99. Signature of health officer		100. Signature of health officer	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.  
M

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY in 1b <u>LIFE</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u>		d. STREET ADDRESS <u>102 BALTIMORE AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PATAPSCO RIVER AT HARBOR FIELD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RICHARD HENRY MONTANARI</u>		4. DATE OF DEATH <u>6/14/58</u> 19 <u>58</u>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 17, 1940</u> 17 yrs.	
9. AGE (In years last birthday) <u>17</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN J. MONTANARI</u>		14. MOTHER'S MAIDEN NAME <u>HELEN DESARRO MONTANARI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>JOHN J. MONTANARI</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9298 DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 min.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 min.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Subject drowned while swimming</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Patapsco River</u>		20f. (City or town) (County) (State) <u>Balto.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK COLLINS, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/16/58</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART JESUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO., md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brock Bradley, Dundalk, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Overbeach</u>			



6586

CERTIFICATE OF DEATH

06573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>Monkton (rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>Manor Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Morrison</u> Last <u>Morrison</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-81</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>unknown Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mike Morrison</u>				14. MOTHER'S MAIDEN NAME <u>Sarah ???? ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Records Sprng Grove State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized atherosclerosis</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>? 5 months</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration, malnutrition, decubitus ulcers,</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22</u> , 19 <u>58</u> , to <u>June 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>58</u> , and that death occurred at <u>2:15A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove Hosp. Baltimore 28, Md.</u> DATE SIGNED <u>6/13/58</u>							
ACTUAL SIGNATURE <u>C. Eugene Watermann</u>				PHYSICIAN'S NAME (Type) <u>C. Eugene Watermann</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clynmalira Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jane V. Brooks</u>				24a. REC'D BY REGISTRAR <u>622 York Rd Towson</u>		24b. REGISTRAR'S SIGNATURE <u>DATE JUN 18 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>John Doe</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>1-1-1900</b></p>		<p>4. Place of birth: <b>City, State</b></p>	
<p>5. Date of death: <b>1-1-1950</b></p>		<p>6. Place of death: <b>City, State</b></p>	
<p>7. Cause of death: <b>Heart Disease</b></p>		<p>8. Manner of death: <b>Natural</b></p>	
<p>9. Signature of physician: <b>Dr. John Doe</b></p>		<p>10. Signature of registrar: <b>John Doe</b></p>	
<p>11. Signature of informant: <b>John Doe</b></p>		<p>12. Signature of witness: <b>John Doe</b></p>	
<p>13. Signature of funeral director: <b>John Doe</b></p>		<p>14. Signature of undertaker: <b>John Doe</b></p>	
<p>15. Signature of cemetery: <b>John Doe</b></p>		<p>16. Signature of burial: <b>John Doe</b></p>	
<p>17. Signature of crematorium: <b>John Doe</b></p>		<p>18. Signature of cremation: <b>John Doe</b></p>	
<p>19. Signature of interment: <b>John Doe</b></p>		<p>20. Signature of disinterment: <b>John Doe</b></p>	
<p>21. Signature of exhumation: <b>John Doe</b></p>		<p>22. Signature of reinterment: <b>John Doe</b></p>	
<p>23. Signature of other: <b>John Doe</b></p>		<p>24. Signature of other: <b>John Doe</b></p>	
<p>25. Signature of other: <b>John Doe</b></p>		<p>26. Signature of other: <b>John Doe</b></p>	
<p>27. Signature of other: <b>John Doe</b></p>		<p>28. Signature of other: <b>John Doe</b></p>	
<p>29. Signature of other: <b>John Doe</b></p>		<p>30. Signature of other: <b>John Doe</b></p>	
<p>31. Signature of other: <b>John Doe</b></p>		<p>32. Signature of other: <b>John Doe</b></p>	
<p>33. Signature of other: <b>John Doe</b></p>		<p>34. Signature of other: <b>John Doe</b></p>	
<p>35. Signature of other: <b>John Doe</b></p>		<p>36. Signature of other: <b>John Doe</b></p>	
<p>37. Signature of other: <b>John Doe</b></p>		<p>38. Signature of other: <b>John Doe</b></p>	
<p>39. Signature of other: <b>John Doe</b></p>		<p>40. Signature of other: <b>John Doe</b></p>	
<p>41. Signature of other: <b>John Doe</b></p>		<p>42. Signature of other: <b>John Doe</b></p>	
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<p>45. Signature of other: <b>John Doe</b></p>		<p>46. Signature of other: <b>John Doe</b></p>	
<p>47. Signature of other: <b>John Doe</b></p>		<p>48. Signature of other: <b>John Doe</b></p>	
<p>49. Signature of other: <b>John Doe</b></p>		<p>50. Signature of other: <b>John Doe</b></p>	
<p>51. Signature of other: <b>John Doe</b></p>		<p>52. Signature of other: <b>John Doe</b></p>	
<p>53. Signature of other: <b>John Doe</b></p>		<p>54. Signature of other: <b>John Doe</b></p>	
<p>55. Signature of other: <b>John Doe</b></p>		<p>56. Signature of other: <b>John Doe</b></p>	
<p>57. Signature of other: <b>John Doe</b></p>		<p>58. Signature of other: <b>John Doe</b></p>	
<p>59. Signature of other: <b>John Doe</b></p>		<p>60. Signature of other: <b>John Doe</b></p>	
<p>61. Signature of other: <b>John Doe</b></p>		<p>62. Signature of other: <b>John Doe</b></p>	
<p>63. Signature of other: <b>John Doe</b></p>		<p>64. Signature of other: <b>John Doe</b></p>	
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<p>67. Signature of other: <b>John Doe</b></p>		<p>68. Signature of other: <b>John Doe</b></p>	
<p>69. Signature of other: <b>John Doe</b></p>		<p>70. Signature of other: <b>John Doe</b></p>	
<p>71. Signature of other: <b>John Doe</b></p>		<p>72. Signature of other: <b>John Doe</b></p>	
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<p>75. Signature of other: <b>John Doe</b></p>		<p>76. Signature of other: <b>John Doe</b></p>	
<p>77. Signature of other: <b>John Doe</b></p>		<p>78. Signature of other: <b>John Doe</b></p>	
<p>79. Signature of other: <b>John Doe</b></p>		<p>80. Signature of other: <b>John Doe</b></p>	
<p>81. Signature of other: <b>John Doe</b></p>		<p>82. Signature of other: <b>John Doe</b></p>	
<p>83. Signature of other: <b>John Doe</b></p>		<p>84. Signature of other: <b>John Doe</b></p>	
<p>85. Signature of other: <b>John Doe</b></p>		<p>86. Signature of other: <b>John Doe</b></p>	
<p>87. Signature of other: <b>John Doe</b></p>		<p>88. Signature of other: <b>John Doe</b></p>	
<p>89. Signature of other: <b>John Doe</b></p>		<p>90. Signature of other: <b>John Doe</b></p>	
<p>91. Signature of other: <b>John Doe</b></p>		<p>92. Signature of other: <b>John Doe</b></p>	
<p>93. Signature of other: <b>John Doe</b></p>		<p>94. Signature of other: <b>John Doe</b></p>	
<p>95. Signature of other: <b>John Doe</b></p>		<p>96. Signature of other: <b>John Doe</b></p>	
<p>97. Signature of other: <b>John Doe</b></p>		<p>98. Signature of other: <b>John Doe</b></p>	
<p>99. Signature of other: <b>John Doe</b></p>		<p>100. Signature of other: <b>John Doe</b></p>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06574

6587  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth 5dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isador</b> Middle <b>Mount</b> Last <b>Mount</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1887</b>
9. AGE (In years last birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired jobber</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Europe</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized and severe</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 28</b> , 19 <b>58</b> , to <b>June 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 26</b> , 19 <b>58</b> , and that death occurred at <b>4:30 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Gertrude Fleischmann, M. D.</b> <b>SPRING GROVE STATE HOSPITAL</b> <b>6-26-58</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Gertrude Fleischmann, M. D.</b> <b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-27-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto Hebrew</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 27 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alb. Lewis</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

428

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

66575

6588

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr11mth3dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Magdalene</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1882</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph L. Nalley</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn L.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the breast (removed in 1953)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>June 19, 19 58</b> , to <b>June 30, 19 58</b> , that I last saw the deceased alive on <b>JUNE 30, 19 58</b> , and that death occurred at <b>6:30 a. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-30-58</b> ACTUAL SIGNATURE <b>Bruno Radawski</b> M.D. PHYSICIAN'S NAME (Type) <b>BRUNO RADALUSKAS</b> <b>Catonsville 28, Maryland</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>July 3, 1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Maryland.</b> 24a. REC'D BY REGISTRAR <b>JUL 2 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The attending physician may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06576

## 658 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Balto. Co.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Steuers REID</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Steuers</u> TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>E</u> (Last) <u>Newhauser</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>1</u> (Year) <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Feb. 15, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>72</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u>1</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Balto Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN NEWHAUSER</u>		14. MOTHER'S MAIDEN NAME <u>Mary Russell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS <u>SAM Newhauser Glen Arm Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure 2 days</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>With Pulmonary Edema</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart Dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office, bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 8, 1953</u> , to <u>5/17, 1958</u> , that I last saw the deceased alive on <u>5/17, 1958</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Clifford F. Hudson</u> M.D.		DATE SIGNED <u>5/1/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>June 4, 1958</u>	
NAME OF CEMETERY OR CREMATORY <u>Naught's</u>		LOCATION (City, town, or county) (State) <u>Glen Arm Md</u>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Clifford F. Hudson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Char F. Evans &amp; Son 8802 Hartford Rd</u>	
DATE <u>JUN 9 '58</u>			

# CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF BIRTH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEAREST RELATIVE

16. SIGNATURE OF CLERK

17. SIGNATURE OF CHURCH CLERK

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF COURT

23. SIGNATURE OF GRAND JURY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF CORONER

27. SIGNATURE OF JURY

28. SIGNATURE OF COURT

29. SIGNATURE OF GRAND JURY

30. SIGNATURE OF JUDGE

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF CORONER

33. SIGNATURE OF JURY

34. SIGNATURE OF COURT

35. SIGNATURE OF GRAND JURY

36. SIGNATURE OF JUDGE

37. SIGNATURE OF SHERIFF

38. SIGNATURE OF CORONER

39. SIGNATURE OF JURY

40. SIGNATURE OF COURT

41. SIGNATURE OF GRAND JURY

42. SIGNATURE OF JUDGE

43. SIGNATURE OF SHERIFF

44. SIGNATURE OF CORONER

45. SIGNATURE OF JURY

46. SIGNATURE OF COURT







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6590

## CERTIFICATE OF DEATH

Reg. Dist. No.

06578

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		c. LENGTH OF STAY IN 1b <u>x Edgemere</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3013 Delmar Ave</u>		d. STREET ADDRESS <u>3013 Delmar Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDWIN</u> Middle <u>C.</u> Last <u>NICHOLS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/1900</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Born at Sea</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gustav Nichols</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Ray E. Nichols</u>		Address <u>3013 Delmar Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE AND ARTERIOSCLEROTIC</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARDIO-VASCULAR RENAL DISEASE</u> DUE TO (c) <u>7 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1951</u> , 19 <u>6-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-2</u> , 19 <u>58</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman J. Halperin</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPARROWS PT, 19 MD 6-5-58</u>	
PHYSICIAN'S NAME (Type) <u>HERMAN J. HALPERIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home, Dundalk, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Ulrich</u>	

0329

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07707

6591

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Pulaski</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 Old Court Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James A.</b> Middle <b>Garfield</b> Last <b>Nunn</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-12-1895</b>
9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b> Hours <b>3</b> Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>for Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Pulaski, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jasper Nunn</b>		14. MOTHER'S MAIDEN NAME <b>Naomi Spence</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.# 1</b>		16. SOCIAL SECURITY NO. <b>1</b>	
17. INFORMANT <b>Nancy Nellie Nunn, Pulaski Virginia</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2-3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 23rd 1958</b> to <b>June 25, 1958</b> , that I last saw the deceased alive on <b>June 24th 1958</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James A. Miller M.D.</b>		ADDRESS (Street, city or town, state) <b>1331 Reisterstown Rd, Pikesville - Md.</b>	
PHYSICIAN'S NAME (Type) <b>James A. Miller M.D.</b>		DATE SIGNED <b>6/27/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-27-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Havel, Pikesville, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUL 15 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

FILE

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>		<p>15. SIGNATURE OF JURY</p>	
<p>16. SIGNATURE OF REGISTRAR</p>		<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF NOTARY</p>		<p>19. SIGNATURE OF JUDGE</p>		<p>20. SIGNATURE OF SHERIFF</p>	

STATE OF MARYLAND

DEPARTMENT OF HEALTH

REGISTERED

IN U.S.

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HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G231, 7/11/58 for

## CERTIFICATE OF DEATH

06579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 mth3dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Oberseider</b> Last <b>Oberseider</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1876</b>
9. AGE (In years last birthday) <b>82 1/2</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Oberseider</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23</b> , 19 <b>58</b> , to <b>June 30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>58</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7-1-58</b> ACTUAL SIGNATURE <b>Augusto Jose Esquibel</b> M.D. PHYSICIAN'S NAME (Type) <b>Augusto Jose Esquibel, M. D.</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Strand Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Balt. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John + Son</b>		ADDRESS <b>28</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 7 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. ...</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1920"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"]	
SIGNATURE OF CLERK [Faint text, possibly "John Doe"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]		SIGNATURE OF JUDGE [Faint text, possibly "John Doe"]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6593

## CERTIFICATE OF DEATH

06581

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9740 Magledt Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mrs. Mary Agnes</u> Middle <u>O'Donnell</u> Last <u>O'Donnell</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2nd</u> Year <u>1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 5, 1867</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Michael Cooney</u>			
14. MOTHER'S MAIDEN NAME <u>Bridget Hughes</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Miss Blanche L. O'Donnell, same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Hypertensive</u> DUE TO (c) <u>Vascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>25 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 Harford Rd BALTO 14 MD</u>			
DATE SIGNED <u>6/2/58</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>6/5/58</u>				22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>			
24a. REC'D BY REGISTRAR <u>JUN 3</u> DATE				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1.2.12 Film G230 6-30-58 et

## CERTIFICATE OF DEATH

06582

Reg. Dist. No.

6594

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 4</u>				c. LENGTH OF STAY IN 1b <u>55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8522 State Oak Rd.</u>				d. STREET ADDRESS <u>18522 State Oak Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edwin L. Otto Sr.</u>				4. DATE OF DEATH Month Day Year <u>June 8 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25, 1880</u>	9. AGE (In years last birthday) yrs. <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Otto</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Finzelburg</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Edwin L. Otto Jr. - 8522 State Oak Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lungs</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>6/5, 1958</u> , to <u>6/8, 1958</u> , that I last saw the deceased alive on <u>6/8, 1958</u> , and that death occurred at <u>6:20 A.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Gordon Grau</u>		ADDRESS (Street, city or town, state) <u>8523 Loch Raven Bldg</u>		DATE SIGNED <u>6/9/58</u>			
PHYSICIAN'S NAME (Type) <u>Gordon Grau, M. D.</u>		TOWN OF <u>MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc.</u>		ADDRESS <u>2431-35 E. Olive St.</u>		24. REC'D BY REGISTRAR DATE <u>JUN 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

Page One of Two

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/24/28		5. PLACE OF BIRTH Memphis, Tenn.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR OF HAIR Brown		9. COLOR OF EYES Blue		10. COLOR OF SKIN Caucasian	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. TIME OF DEATH 10:15 AM		15. DATE OF DEATH 12/31/63	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF REGISTRAR John Doe		18. SIGNATURE OF WITNESS Jane Smith		19. SIGNATURE OF DECEASED James Earl Ray		20. SIGNATURE OF NEXT OF KIN Mother	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF NEXT OF KIN Mother		23. SIGNATURE OF NEXT OF KIN Father		24. SIGNATURE OF NEXT OF KIN Sister		25. SIGNATURE OF NEXT OF KIN Brother	
26. SIGNATURE OF NEXT OF KIN Brother		27. SIGNATURE OF NEXT OF KIN Sister		28. SIGNATURE OF NEXT OF KIN Mother		29. SIGNATURE OF NEXT OF KIN Father		30. SIGNATURE OF NEXT OF KIN Brother	
31. SIGNATURE OF NEXT OF KIN Sister		32. SIGNATURE OF NEXT OF KIN Mother		33. SIGNATURE OF NEXT OF KIN Father		34. SIGNATURE OF NEXT OF KIN Brother		35. SIGNATURE OF NEXT OF KIN Sister	
36. SIGNATURE OF NEXT OF KIN Mother		37. SIGNATURE OF NEXT OF KIN Father		38. SIGNATURE OF NEXT OF KIN Brother		39. SIGNATURE OF NEXT OF KIN Sister		40. SIGNATURE OF NEXT OF KIN Brother	
41. SIGNATURE OF NEXT OF KIN Sister		42. SIGNATURE OF NEXT OF KIN Brother		43. SIGNATURE OF NEXT OF KIN Mother		44. SIGNATURE OF NEXT OF KIN Father		45. SIGNATURE OF NEXT OF KIN Brother	
46. SIGNATURE OF NEXT OF KIN Father		47. SIGNATURE OF NEXT OF KIN Brother		48. SIGNATURE OF NEXT OF KIN Sister		49. SIGNATURE OF NEXT OF KIN Mother		50. SIGNATURE OF NEXT OF KIN Brother	
51. SIGNATURE OF NEXT OF KIN Brother		52. SIGNATURE OF NEXT OF KIN Sister		53. SIGNATURE OF NEXT OF KIN Mother		54. SIGNATURE OF NEXT OF KIN Father		55. SIGNATURE OF NEXT OF KIN Brother	
56. SIGNATURE OF NEXT OF KIN Sister		57. SIGNATURE OF NEXT OF KIN Mother		58. SIGNATURE OF NEXT OF KIN Father		59. SIGNATURE OF NEXT OF KIN Brother		60. SIGNATURE OF NEXT OF KIN Sister	
61. SIGNATURE OF NEXT OF KIN Mother		62. SIGNATURE OF NEXT OF KIN Father		63. SIGNATURE OF NEXT OF KIN Brother		64. SIGNATURE OF NEXT OF KIN Sister		65. SIGNATURE OF NEXT OF KIN Brother	
66. SIGNATURE OF NEXT OF KIN Sister		67. SIGNATURE OF NEXT OF KIN Brother		68. SIGNATURE OF NEXT OF KIN Mother		69. SIGNATURE OF NEXT OF KIN Father		70. SIGNATURE OF NEXT OF KIN Brother	
71. SIGNATURE OF NEXT OF KIN Father		72. SIGNATURE OF NEXT OF KIN Brother		73. SIGNATURE OF NEXT OF KIN Sister		74. SIGNATURE OF NEXT OF KIN Mother		75. SIGNATURE OF NEXT OF KIN Brother	
76. SIGNATURE OF NEXT OF KIN Brother		77. SIGNATURE OF NEXT OF KIN Sister		78. SIGNATURE OF NEXT OF KIN Mother		79. SIGNATURE OF NEXT OF KIN Father		80. SIGNATURE OF NEXT OF KIN Brother	
81. SIGNATURE OF NEXT OF KIN Sister		82. SIGNATURE OF NEXT OF KIN Mother		83. SIGNATURE OF NEXT OF KIN Father		84. SIGNATURE OF NEXT OF KIN Brother		85. SIGNATURE OF NEXT OF KIN Sister	
86. SIGNATURE OF NEXT OF KIN Mother		87. SIGNATURE OF NEXT OF KIN Father		88. SIGNATURE OF NEXT OF KIN Brother		89. SIGNATURE OF NEXT OF KIN Sister		90. SIGNATURE OF NEXT OF KIN Brother	
91. SIGNATURE OF NEXT OF KIN Brother		92. SIGNATURE OF NEXT OF KIN Sister		93. SIGNATURE OF NEXT OF KIN Mother		94. SIGNATURE OF NEXT OF KIN Father		95. SIGNATURE OF NEXT OF KIN Brother	
96. SIGNATURE OF NEXT OF KIN Sister		97. SIGNATURE OF NEXT OF KIN Mother		98. SIGNATURE OF NEXT OF KIN Father		99. SIGNATURE OF NEXT OF KIN Brother		100. SIGNATURE OF NEXT OF KIN Sister	

1. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

2. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

3. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

4. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

5. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

6. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

7. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

8. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

9. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.

10. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 31st day of December, 1963.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06583

6595

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodstock</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hernwood Road</b>				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>J.</b> Last <b>Peach Sr.</b>			4. DATE OF DEATH Month <b>June</b> Day <b>3rd</b> Year <b>1958</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <del>WIDOWED</del> <del>RE-MARRIED</del> <del>INVESTED</del>	8. DATE OF BIRTH <b>Aug. 15, 1878</b>		9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Granite Business</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles J. Peach</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Kelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Nora M. Peach</b> Address <b>Hernwood Road, Woodstock.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma lung - it - c</b> 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized carcinomatosis</b> DUE TO (c) <b>Chronic bronchitis - c. Sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>20 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL</b> , 19 <b>50</b> to <b>JUNE 3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JUNE 3</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P.</b> M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>Thomas E. Wheeler</b> ADDRESS (Street, city or town, state) <b>3601 CLIFMAR RD</b> DATE SIGNED <b>6/4/58</b> PHYSICIAN'S NAME (Type) <b>THOMAS E. WHEELER</b> <b>Balto 5 - Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-6, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Alphonsus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodstock, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b> <b>LORING BYERS</b>			ADDRESS <b>8728 Liberty Road</b> <b>Randallstown, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. E. ...</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6596

CERTIFICATE OF DEATH

06584

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE CO.</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TEXAS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TEXAS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>NONE</b>		d. STREET ADDRESS <b>TEXAS</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WILLIAM</b> Middle <b>PEACOCK</b> Last <b>PEACOCK</b>		<b>4. DATE OF DEATH</b> Month <b>JUNE</b> Day <b>19</b> Year <b>19 58</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JUNE 1, 1872</b>
<b>9. AGE</b> (In years last birthday) <b>86</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>BARTENDER - RETIRED</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>STORE BAR</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>UNKNOWN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>219-22-2817</b>	
<b>17. INFORMANT</b> <b>Family Records</b>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO <b>Arteriosclerosis - general</b> (c) <b>Diabetes - mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20c. TIME OF INJURY</b> Hour <b>19</b> Month <b>6</b> Day <b>17</b> Year <b>1958</b> p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>1-1-1950</b> <b>to</b> <b>6-19-58</b> <b>that I last saw the deceased alive on</b> <b>6-17-1958</b> <b>and that death occurred at</b> <b>6:30 A.M.</b> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <b>James G. Saffell</b> <b>M.D.</b> <b>Reisterstown Md</b> <b>6-19-58</b> <b>PHYSICIAN'S NAME (Type)</b> <b>James G. Saffell MD</b> <b>Reisterstown Md</b> <b>6-19-58</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>JUNE 21, 1958</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>POPLAR GROVE CEMETERY</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>COCKEYSVILLE, MARYLAND</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John Burns Sims</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 24 58</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Deborah Smith</b>			



6597

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armcast Nursing Home</b>		d. STREET ADDRESS <b>309 Lochview Terrace</b>	
3. NAME OF DECEASED (Type or print) First <b>INEZ</b> Middle <b>PEDDICORD</b> Last <b>PEDDICORD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Rnox Peregoy</b>		14. MOTHER'S MAIDEN NAME <b>Maria Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT Address <b>Mr. T. M. Peddicord-309 Lochview Terrace</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Hypertensive Cardio-Renal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Vascular Disease</b> DUE TO (c) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 17</b> , 19 <b>57</b> , to <b>June 19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 19</b> , 19 <b>58</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		ADDRESS (Street, city or town, state) <b>7501 York Rd</b> DATE SIGNED <b>July 20, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>		<b>Tolson &amp; Co</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/23/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tipton &amp; Sons</b> ADDRESS <b>Balto - 17, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Tipton</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



CERTIFICATE OF DEATH

6200

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH May 23, 1968		15. TIME OF DEATH 10:10 AM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF DECEASED James Earl Ray		19. SIGNATURE OF WITNESS John Edgar Hoover		20. SIGNATURE OF DECEASED James Earl Ray	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF DECEASED James Earl Ray		24. SIGNATURE OF WITNESS John Edgar Hoover		25. SIGNATURE OF DECEASED James Earl Ray	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS John Edgar Hoover		28. SIGNATURE OF DECEASED James Earl Ray		29. SIGNATURE OF WITNESS John Edgar Hoover		30. SIGNATURE OF DECEASED James Earl Ray	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF WITNESS John Edgar Hoover		33. SIGNATURE OF DECEASED James Earl Ray		34. SIGNATURE OF WITNESS John Edgar Hoover		35. SIGNATURE OF DECEASED James Earl Ray	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF WITNESS John Edgar Hoover		38. SIGNATURE OF DECEASED James Earl Ray		39. SIGNATURE OF WITNESS John Edgar Hoover		40. SIGNATURE OF DECEASED James Earl Ray	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF WITNESS John Edgar Hoover		43. SIGNATURE OF DECEASED James Earl Ray		44. SIGNATURE OF WITNESS John Edgar Hoover		45. SIGNATURE OF DECEASED James Earl Ray	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF WITNESS John Edgar Hoover		48. SIGNATURE OF DECEASED James Earl Ray		49. SIGNATURE OF WITNESS John Edgar Hoover		50. SIGNATURE OF DECEASED James Earl Ray	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF WITNESS John Edgar Hoover		53. SIGNATURE OF DECEASED James Earl Ray		54. SIGNATURE OF WITNESS John Edgar Hoover		55. SIGNATURE OF DECEASED James Earl Ray	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF WITNESS John Edgar Hoover		58. SIGNATURE OF DECEASED James Earl Ray		59. SIGNATURE OF WITNESS John Edgar Hoover		60. SIGNATURE OF DECEASED James Earl Ray	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF WITNESS John Edgar Hoover		63. SIGNATURE OF DECEASED James Earl Ray		64. SIGNATURE OF WITNESS John Edgar Hoover		65. SIGNATURE OF DECEASED James Earl Ray	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF WITNESS John Edgar Hoover		68. SIGNATURE OF DECEASED James Earl Ray		69. SIGNATURE OF WITNESS John Edgar Hoover		70. SIGNATURE OF DECEASED James Earl Ray	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF WITNESS John Edgar Hoover		73. SIGNATURE OF DECEASED James Earl Ray		74. SIGNATURE OF WITNESS John Edgar Hoover		75. SIGNATURE OF DECEASED James Earl Ray	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF WITNESS John Edgar Hoover		78. SIGNATURE OF DECEASED James Earl Ray		79. SIGNATURE OF WITNESS John Edgar Hoover		80. SIGNATURE OF DECEASED James Earl Ray	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF WITNESS John Edgar Hoover		83. SIGNATURE OF DECEASED James Earl Ray		84. SIGNATURE OF WITNESS John Edgar Hoover		85. SIGNATURE OF DECEASED James Earl Ray	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF WITNESS John Edgar Hoover		88. SIGNATURE OF DECEASED James Earl Ray		89. SIGNATURE OF WITNESS John Edgar Hoover		90. SIGNATURE OF DECEASED James Earl Ray	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF WITNESS John Edgar Hoover		93. SIGNATURE OF DECEASED James Earl Ray		94. SIGNATURE OF WITNESS John Edgar Hoover		95. SIGNATURE OF DECEASED James Earl Ray	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF WITNESS John Edgar Hoover		98. SIGNATURE OF DECEASED James Earl Ray		99. SIGNATURE OF WITNESS John Edgar Hoover		100. SIGNATURE OF DECEASED James Earl Ray	

THIS CERTIFICATE OF DEATH IS A LEGAL DOCUMENT AND MUST BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN A COMPLETE RECORD OF ALL DEATHS IN THE CITY OF BALTIMORE. THIS CERTIFICATE IS VALID FOR A PERIOD OF FIVE YEARS FROM THE DATE OF DEATH. AFTER THAT TIME, IT MUST BE RE-REGISTERED. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE REGISTRAR'S OFFICE AT (410) 396-1000.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6608 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06580

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork</u>	
c. LENGTH OF STAY IN 1b <u>7-8 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hanford Rd.</u>		d. STREET ADDRESS <u>Hanford Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Edward Valentine O'Donnell</u>		4. DATE OF DEATH <u>6/21/58</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Fork Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Schrider</u>		14. MOTHER'S MAIDEN NAME <u>Ann T. Traff.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Gordon</u>		Address <u>Fork Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Congestive Failure</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unk</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christian Cemetery</u>
		22d. LOCATION (City, town, or county) (State) <u>Fork, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. Evans &amp; Son, 148 W. Mt Royal</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6598 CERTIFICATE OF DEATH

06586

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>22 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> <span style="float: right;">b. COUNTY <b>Alleghany</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Covington</b> <span style="float: right;">83x-3</span> d. STREET ADDRESS <b>121 Prospect Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>WILLIAM LLOYD PLOTT</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>June 18 1958</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 5, 1897</b>		<b>9. AGE</b> (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Driver</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Taxicab</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Rockbridge Co. Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		
<b>13. FATHER'S NAME</b> <b>James William Plott</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Hall</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <b>WW I</b>		<b>17. INFORMANT</b> Address <b>Clinical Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LIVER WITH GENERALIZED METASTASIS</b> DUE TO <b>LAENNEC'S CIRRHOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that</b> <del>attended</del> <b>attended</b> the deceased from <b>May 27</b> , 19 <b>58</b> , to <b>June 18</b> , 19 <b>58</b> , <del>and that death occurred on</del> <b>and that death occurred on</b> <b>June 18, 1958, at 2:45 P.M.</b> from the causes and on the date stated above.									
<b>ACTUAL SIGNATURE</b> <i>Donald D. Mark</i>				<b>ADDRESS</b> (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		<b>DATE SIGNED</b> <b>6/19/58</b>			
<b>PHYSICIAN'S NAME</b> (Type) <b>DONALD D. MARK, M.D.</b>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>22b. DATE THEREOF</b> <b>6-19-58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Covington, Virginia</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Wm Cook - Blight Inc.</i>				<b>ADDRESS</b> <b>Wm. Cook-Blight, Inc. 5009 Harford Rd. Balto. 14, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>JUN 23 '58</b>			

To: R.M. Loving Funeral Home, Maple & Riverside Ave., Covington, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 15

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by the funeral director, and completely filled by the attending physician and completely filled by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6599

## CERTIFICATE OF DEATH

06587

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Hall</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Vernon Henry Purkey</b>		4. DATE OF DEATH Month Day Year <b>6-5-58</b> 19 <b>19</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-26- 1893</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mining</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>mine</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dock Franklin Purkey</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Cox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWF 1918-19, 401-01-8265</b>	
17. INFORMANT <b>Mrs. Vernon Purkey</b>		Address <b>White Hall, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerosis</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> to <b>June 4</b> , 19 <b>58</b> that I last saw the deceased alive on <b>June 4</b> , 19 <b>58</b> , and that death occurred at <b>11:00</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>White Hall, Md.</b> DATE SIGNED <b>Wm. E. Johnson</b>			
ACTUAL SIGNATURE <b>Wm. E. Johnson</b>		M.D. <b>White Hall, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>6-6-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pound, Va.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>William E. Johnson</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 6 '58</b>	
ADDRESS <b>1557 Eastern Ave. Baltimore 12, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. E. Johnson</b>	

CHINESE UNIVERSITY OF POSTAL AND TELECOMMUNICATIONS



# MD. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6600

## CERTIFICATE OF DEATH

Reg. Dist. No.

00588

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forrest Haven-Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b> d. STREET ADDRESS <b>637 Frederick Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret E. Ripley</b> First Middle Last		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-19-1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Ripley</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Shaffer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>	
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Frederick L. Ripley-136 Willard Street</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X CEREBRAL VASCULAR DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b> DUE TO (c) <b>DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/1</b> , 19 <b>58</b> , to <b>6/3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/2</b> , 19 <b>58</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5800 Edmondson Ave.</b> DATE SIGNED <b>6/4/58</b>			
ACTUAL SIGNATURE <b>John H. Shaw</b>		PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D. BALD-28 MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 5-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Old Court Rd. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. P. Hippeet</b> ADDRESS <b>1300 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>JUN 6 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[English](#) [Deutsch](#) [Français](#) [Español](#) [Italiano](#)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 8.9 FilmG230 6-25-58 et  
6601  
CERTIFICATE OF DEATH

06589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>636 North Bend Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <b>Thomas</b> Middle <b>Rooney</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 9, 1903</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Social Security-</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>late Michael J. Rooney</b>				14. MOTHER'S MAIDEN NAME <b>late Mary----</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Apt. Miss Laura Rooney, 2800 Ontario Rd. N.W. 401 Washington 9, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X HYPERTENSIVE &amp; ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS+</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 1956</b> to <b>6/19 1958</b> , that I last saw the deceased alive on <b>6/18 1958</b> , and that death occurred at <b>1 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thos E Roach</b>				M.D. <b>3629 Edmondson Ave 6/20/58</b>			
PHYSICIAN'S NAME (Type) <b>Thos E Roach</b>				<b>Baltimore-29-Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>June 21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas' Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Sterling, Kentucky</b>	
22e. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson Ave</b>				22f. REC'D BY REGISTRAR <b>June 24 58</b>		22g. REGISTRAR'S SIGNATURE <b>Reed</b>	

CERTIFICATE OF DEATH

1901

NAME OF DECEASED John J. Jones		SEX Male		AGE 45	
DATE OF DEATH Jan 15, 1901		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Myocarditis		MANNER OF DEATH Natural	
DATE OF BIRTH Jan 1, 1856		PLACE OF BIRTH Maryland		CITY Baltimore	
FATHER'S NAME John J. Jones		MOTHER'S NAME Mary J. Jones		FATHER'S OCCUPATION Carpenter	
MOTHER'S OCCUPATION Housewife		DECEASED'S OCCUPATION Carpenter		EDUCATION Common School	
RELIGION Roman Catholic		MARITAL STATUS Married		WIFE'S NAME Mary J. Jones	
PREVIOUS ILLNESS None		DATE OF ONSET Jan 10, 1901		SYMPTOMS Chest pain, shortness of breath	
TREATMENT None		HISTORY Patient was healthy until Jan 10, 1901, when he began to feel chest pain and shortness of breath. He was unable to work and was confined to his bed. He died on Jan 15, 1901.		TESTIMONY I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts and circumstances of the death of the above named person.	
SIGNATURE OF PHYSICIAN John J. Jones		DATE Jan 15, 1901		PLACE Baltimore	
SIGNATURE OF WITNESSES John J. Jones, Mary J. Jones		DATE Jan 15, 1901		PLACE Baltimore	
SIGNATURE OF CORONER John J. Jones		DATE Jan 15, 1901		PLACE Baltimore	
SIGNATURE OF JURY John J. Jones, Mary J. Jones		DATE Jan 15, 1901		PLACE Baltimore	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6602

CERTIFICATE OF DEATH

06590

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Parkton</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Parkton</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Rd.</u>				d. STREET ADDRESS <u>Old York Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>B.</u> Last <u>Rosier</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Donathon Baker</u>				14. MOTHER'S MAIDEN NAME <u>Hester Horseman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-360079</u>		17. INFORMANT <u>Dr. Herbert Rosier, Parkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO <u>5 yrs</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>one day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>6-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-19</u> , 19 <u>58</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis Schatanoff</u>				ADDRESS (Street, city or town, state) <u>New Freedom, York Co., Pa.</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS SCHATANOFF, M.D.</u>				DATE SIGNED <u>6/21/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 23 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>New Freedom Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>				ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Althea</u>			







6603

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>647 North Bend Road</b>		d. STREET ADDRESS <b>647 North Bend Road</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH GEORGE ROTH</b>		4. DATE OF DEATH <b>June 26 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB-7-1891</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supr</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hutzel Bros Phila Pa</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Roth</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Stumpner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both now) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>14-01-0861</b>	
17. INFORMANT <b>Caroline E. Roth</b>		Address <b>647 North Bend Rd 29</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X cerebral hemorrhage</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>6 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-7-57</b> to <b>6-26-58</b> , that I last saw the deceased alive on <b>6/13-58</b> , and that death occurred at <b>3 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. W. Scheye M.D.</b>		ADDRESS (Street, city or town, state) <b>3921 EDMONDSON BALTO 29 MD.</b>	
PHYSICIAN'S NAME (Type) <b>H. W. SCHEYE M.D.</b>		DATE SIGNED <b>6/26/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 30, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New National Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Coupl</b>		ADDRESS <b>5311 Edmondson Ave</b>	
24a. REC'D BY REGISTRAR <b>JUN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

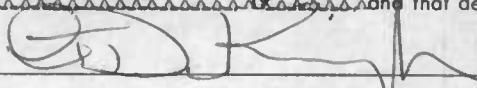
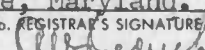
NAME OF DECEASED JAMES H. HARRIS		AGE 45	
SEX Male		RACE White	
DATE OF DEATH April 15, 1903		PLACE OF DEATH Home	
CITY Baltimore		COUNTY Baltimore	
STATE Maryland		COUNTRY United States	
OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease	
DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several Months	
TREATMENT Medical		PLACE OF BURIAL Catholick Cemetery	
DATE OF BURIAL April 18, 1903		PLACE OF INTERMENT Catholick Cemetery	
SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF WITNESSES John Doe, John Smith	
SIGNATURE OF PHYSICIAN Dr. John Doe		SIGNATURE OF MINISTER Rev. John Smith	
SIGNATURE OF CORONER John Doe		SIGNATURE OF JURY John Doe, John Smith	
SIGNATURE OF REGISTRAR John Doe		SIGNATURE OF CLERK John Doe	

6604

# CERTIFICATE OF DEATH

06592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>54 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>4002 Mortimer Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter</b>		First <b>(NMI)</b>		Middle <b>ROTH</b>		Last	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1890</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hauling.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John William Roth</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Petty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-12-1191</b>		17. INFORMANT <b>ClinRec.Vet.Adm.Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF THE BLADDER</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 14</b> , 19 <b>58</b> , to <b>June 7</b> , 19 <b>58</b> , and that death occurred at <b>3:20A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE 		M.D. <b>VAH. FT. HOWARD, MD.</b>		DATE SIGNED <b>June 7, 1958</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Garfield D. KINGTON, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-10-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge,</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook - Blight, Inc.</b>		ADDRESS <b>6009 Harford Rd</b>		24a. REC'D BY REGISTRAR <b>JUN 9 '58</b>		24b. REGISTRAR'S SIGNATURE 	

VS A15 (4)  
J5M 10/57

# CERTIFICATE OF DEATH

1900

11

MINN. STATE DEPT. OF HEALTH - BATHING 15

Name of Deceased		Sex		Age		Date of Birth	
John J. Smith		Male		45		Jan. 1, 1855	
Place of Birth		Occupation		Cause of Death		Date of Death	
St. Paul, Minn.		Farmer		Heart Disease		Jan. 15, 1900	
Place of Death		Physician		Hospital		Burial Place	
St. Paul, Minn.		Dr. J. H. Smith		St. Paul Hospital		St. Paul, Minn.	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Date of Report		Date of Certificate		Date of Burial		Date of Interment	
Jan. 15, 1900		Jan. 15, 1900		Jan. 15, 1900		Jan. 15, 1900	

6605

## CERTIFICATE OF DEATH

06593

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ROSEWOOD BALTO. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILL</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD STATE TRAINING School</u>		d. STREET ADDRESS <u>1646 PENN. AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL Joseph SALKIN</u>		4. DATE OF DEATH Month Day Year <u>6 21 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/14</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORRIS BURK SALKIN</u>		14. MOTHER'S MAIDEN NAME <u>LENA SCHARLEW SALKIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>ROSEWOOD RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO <u>Chronic Bronchitis with infil-8 mor-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>tration of the lung (chest)</u> DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 26, 1957</u> to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 21, 1958</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>St. S. Butler</u> M.D.		ADDRESS (Street, city or town, State) <u>Owings Mills, Md</u> DATE SIGNED <u>6/21/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-22-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young men</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Mc</u> ADDRESS <u>2100 Guitaw Pl</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 23 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

2002

MASSACHUSETTS DEPARTMENT OF HEALTH

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.



6606

CERTIFICATE OF DEATH

Reg. Dist. No.

06594

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>19 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4			
d. STREET ADDRESS <b>1907 Wheeler Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THEODORE</b> Middle <b>R.</b> Last <b>SAUNDERS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 12, 1906</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building Construction)</b> Baltimore, Maryland			
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William H. Saunders</b>				14. MOTHER'S MAIDEN NAME <b>Pearl Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>217-07-5222</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH METASTASIS TO PORTA</b> <b>151X</b> <del>DOCK</del> <b>HEPATICUS, LIVER, AND ABDOMINAL WALL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 6, 1958</b> , to <b>June 25, 1958</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 6/25/58</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b>				PHYSICIAN'S NAME (Type) <b>CH IEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-30-58</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rayner Sanders</b>				24. REC'D BY REGISTRAR DATE <b>6/26/58</b>			
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2796

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
John H. H. H. H.		25		Male		White		1900		Baltimore, Md.		1925		Baltimore, Md.	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION	
John H. H. H.		Mary H. H. H.		Farmer		Homemaker		High School		High School		Roman Catholic		Roman Catholic	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS	
Heart Disease		Natural		6 Months		Medical		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION		FEE		REMARKS		FEE		REMARKS	
J. H. H. H.		J. H. H. H.		1925		Baltimore, Md.		\$1.00		None		\$1.00		None	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6607

## CERTIFICATE OF DEATH

06595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> 3V01-4 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home-1002 N. Rolling Rd.</b>				d. STREET ADDRESS <b>617 N. Denison St.</b>			
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>D.</b> Last <b>SCHAEFER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3, 1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.		IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Michael Fitzpatrick</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Robert T. Schaefer - 617 N. Denison St.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>175.0 Carcinoma of Ovary</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 yrs.</b> DUE TO (c) <b>2 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 26, 1958</b> to <b>June 27, 1958</b> , that I last saw the deceased alive on <b>June 26, 1958</b> , and that death occurred at <b>9 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>D. C. MacLaughlin</b>				ADDRESS (Street, city or town, state) <b>4508 Edmondson Village</b> DATE SIGNED <b>6/28/58</b>			
PHYSICIAN'S NAME (Type) <b>D. C. MacLaughlin</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/1/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Balto 17</b>				24a. REC'D BY REGISTRAR <b>MD</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Dickner</b>	

CERTIFICATE OF DEATH

6007

DEATH OF  
JAMES  
BROWN

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
RELIGION		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN	
SIGNATURE OF JUDGE		SIGNATURE OF CORONER	
SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6609

## CERTIFICATE OF DEATH

Reg. Dist. No. 06596

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Etchison</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Newburg Ave.</u>				d. STREET ADDRESS <u>RFD # 2 Woodbine</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ALMEDA</u> Middle <u>S.</u> Last <u>SHEFFER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 15, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>New Market, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Oliver P. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Annie Mary Hilton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs James Hilton, Woodbine, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced arterio-sclerosis</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>My Sanguine Pt. foot - Thrombophlebitis</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I attended the deceased from <u>June 10, 1958</u> to <u>June 24, 1958</u> , that I last saw the deceased alive on <u>June 23, 1958</u> , and that death occurred at <u>7-10</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 Wetherbee Ave</u> DATE SIGNED <u>  </u> ACTUAL SIGNATURE <u>Wetherbee Fort</u> M.D. <u>  </u> PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 26, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Cooksville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Mylesworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

CERTIFICATE OF DEATH

6603

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12/5/30		6. BIRTH PLACE MOBILE, ALA.	
7. DECEASED DATE 4/4/68		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE FBI HEADQUARTERS, BALTIMORE	
10. DECEASED CAUSE HEART DISEASE		11. DECEASED DISEASE CORONARY ARTERY DISEASE		12. DECEASED DIAGNOSIS MYOCARDIAL INFARCTION	
13. DECEASED DOCTOR DR. JAMES H. HARRIS		14. DECEASED HOSPITAL JOHN SEVERA HOSPITAL		15. DECEASED CITY BALTIMORE	
16. DECEASED COUNTY BALTIMORE		17. DECEASED STATE MD		18. DECEASED ZIP 21201	
19. DECEASED SIGNATURE JAMES EARL RAY		20. DECEASED ADDRESS 1000 17th St NW, Washington, DC		21. DECEASED PHONE 202-462-1000	
22. DECEASED OCCUPATION Attorney		23. DECEASED RELIGION Methodist		24. DECEASED MARRIAGE Married	
25. DECEASED EDUCATION Bachelor's Degree		26. DECEASED SERVICE None		27. DECEASED AGENCY FBI	
28. DECEASED SIGNATURE JAMES EARL RAY		29. DECEASED ADDRESS 1000 17th St NW, Washington, DC		30. DECEASED PHONE 202-462-1000	
31. DECEASED OCCUPATION Attorney		32. DECEASED RELIGION Methodist		33. DECEASED MARRIAGE Married	
34. DECEASED EDUCATION Bachelor's Degree		35. DECEASED SERVICE None		36. DECEASED AGENCY FBI	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6610

## CERTIFICATE OF DEATH

Reg. Dist. No.

06597

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Batonsville,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>111 Rosewood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Iva</b> Middle <b>Carr</b> Last <b>Shipley</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1888</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>A.A. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Cheever Carr</b>		14. MOTHER'S MAIDEN NAME <b>Florence O. Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Geo. L. Wehland</b>		Address <b>111 Rosewood Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HTCVD + ASCVD</b> DUE TO (c) <b>(Pt under care of Dr. T. Herbert-Elliott City)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous CVA 6 wks ago - Pneumonia 2 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/13, 1958</b> , to <b>6/17, 1958</b> , that I last saw the deceased alive on <b>6/17, 1958</b> , and that death occurred at <b>12:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Victor F. Keen</b>		DATE SIGNED <b>6/13/58</b>	
PHYSICIAN'S NAME (Type) <b>Victor F. Keen M.D.</b>		ADDRESS (Street, city or town, state) <b>715 Frederick Ave.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, lawn, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. *Introduction*

John O. Mitchell & Sons, Inc. 1900 "Great Britain"

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06598**

**6611**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Baltimore (21)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>301 Eastern Blvd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARY GOLDIE SLADE</b>				4. DATE OF DEATH <b>June 19 1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 30, 1890</b>	
				9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Stanley Slade</b>				14. MOTHER'S MAIDEN NAME <b>Sarah A. Tinkler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elmer P. Slade, above</b>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Secondary Anaemia</b> <b>153.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Transverse Colon</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>3 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1 1956</b> to <b>June 19 1958</b> that I last saw the deceased alive on <b>June 18 1958</b> and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Balto 6 Md.</b> DATE SIGNED <b>6/19/58</b>							
ACTUAL SIGNATURE <b>JMBanngardner</b>				PHYSICIAN'S NAME (Type) <b>Charles E. Schimunek</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 23 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6481

## CERTIFICATE OF DEATH

Reg. Dist. No.

06599

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALETHROPE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 HALETHROPE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2030 Northeast Ave</u>		d. STREET ADDRESS <u>2030 Northeast Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA GRIMES SMITH</u>		4. DATE OF DEATH Month Day Year <u>JUNE 20 19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-4-93</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Clara</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>John H. Grimes, Sr. 2030 Northeast Ave</u>	
17. INFORMANT <u>John H. Grimes, Sr.</u> Address <u>2030 Northeast Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatitis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Stomach Metastasis</u> DUE TO (c) <u>UnKnown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 19</u> , 19 <u>58</u> , to <u>JUNE 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 19</u> , 19 <u>58</u> , and that death occurred at <u>2:12 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Hunt</u> M.D. <u>1607 W. Mulberry St.</u>		DATE SIGNED <u>6-23-58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. HUNT</u>		<u>1607 W. Mulberry St. MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay O. Wilson</u> ADDRESS <u>1000</u>		24a. RECEIVED BY REGISTRAR <u>JUN 27 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>John H. Grimes</u>	







6482

## CERTIFICATE OF DEATH

Reg. Dist. No.

06600

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1241 Leeds Terrace</u>		d. STREET ADDRESS <u>1241 Leeds Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>HERBERT</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Cline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Rose M. Smith - 1241 Leeds Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>Generalized A.S.C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>June 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>58</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Healy</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>	
DATE SIGNED <u>6/6/58</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. J. Hickner &amp; Sons - Balto 17</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>	
ADDRESS <u>Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

6612

## CERTIFICATE OF DEATH

Reg. Dist. No.

06601

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>840 Pierce St.,</b>	
3. NAME OF DECEASED (Type or print) <b>(Served as Clinton Johnson)</b> <b>Clinton J. SMITH</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1889</b>
9. AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
11. BIRTHPLACE (State or foreign country) <b>Westminster, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Smith</b>		14. MOTHER'S MAIDEN NAME <b>Alice F. Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>218-10-1021</b>	
17. INFORMANT <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT AND LEFT.</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>PULMONARY CONGESTION.</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE.</b> Interval between onset and death <b>2 days</b> <b>2 days</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-93x			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1</b> 19 <b>57</b> to <b>June 6</b> 19 <b>58</b> , that I last saw the deceased <b>June 6</b> and that death occurred at <b>10:00 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6/7/58</b>			
ACTUAL SIGNATURE <i>Charles T. Fitch</i>		M.D. <b>VAH. FT. HOWARD, MD.</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES T FITCH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-11-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>		ADDRESS <b>802 Madison</b>	
24a. REC'D BY REGISTRAR <b>JUN 10 '58</b>		DATE	
24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>			

Charles R. Law Mortuary, 802 Madison Ave., Baltimore, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled out by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MADE IN U.S.A. CONTENT

WIND BLOWING

CERTIFICATE OF DEATH

1918

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Office of Registrar

2 days

2 days

1 day

1 day

1 day

1 day

1 day

1 day

1 day

1 day

1 day

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6613

## CERTIFICATE OF DEATH

## 06602

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>			c. LENGTH OF STAY IN 1b <u>14 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>Box 38</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>THOMAS</u> Middle <u>D.</u> Last <u>SMITH</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 19, 1924</u>	
9. AGE (In years last birthday) yrs. <u>34</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>School Bus</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Horace Smith</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Sterner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>219-18-6586</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>237x</u> IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <u>Myositis Ossificans Dorsalis spinis Muscles. Operations 6/3/58, Bilateral Trephining. 6/4/58, Ventriculogram; cerebellar tumor removed.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 23</u> , 19 <u>58</u> , to <u>June 6</u> , 19 <u>58</u> , and that death occurred at <u>3:13 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph M. Miller</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6/6/58</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH M. MILLER, M.D., Chief, Surgical Service VAH, FT. HOWARD, MARYLAND</u>				M.D. <u>VA HOSPITAL, FORT HOWARD, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>E.U.B. Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greenmount, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Tipton Funeral Home, Hampstead, Md.</u>				ADDRESS <u>Hampstead, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>				DATE <u>JUN 11 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6614

Item 8 Film 231 7-14-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

06603

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catanoville</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of the Pines</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>1241 Voght Ave.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph W. Spence</u>				4. DATE OF DEATH Month Day Year <u>June 2 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1902 May 16-58</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cattle Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cattle Industry</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Spence</u>				14. MOTHER'S MAIDEN NAME <u>Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Peace time</u>				16. SOCIAL SECURITY NO. <u>216-09-3908</u>			
17. INFORMANT <u>Elaine Blackman</u>				Address <u>1241 Voght Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca of Colon</u> DUE TO (b) <u>Ca of Left Lung</u> DUE TO (c) <u>163x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>37m</u> INTERVAL BETWEEN ONSET AND DEATH <u>13y.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-16</u> , 1958, to <u>6-2</u> , 1958, that I last saw the deceased alive on <u>6-1</u> , 1958, and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Ave. Baltimore-28, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>				DATE SIGNED <u>6-3-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Edmondson Ave. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Rose</u>				ADDRESS <u>5646 Carville Ave.</u>			
24a. REC'D BY REGISTRAR <u>JUN 6 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06604

6615

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth19days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Langdon</b> Last <b>Spencer</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1867</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Marshall Langdon</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor B. Brodie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 14</b> , 19 <b>58</b> , to <b>June 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 26</b> , 19 <b>58</b> , and that death occurred at <b>3:30 a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 6-26-58</b> ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D. PHYSICIAN'S NAME (Type) <b>Bruno Radauskas, M. D.</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>June 27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29 MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>30 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Witzke</b>			





6616

## CERTIFICATE OF DEATH

Reg. Dist. No. 06605

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN lb <u>52</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 Smithwood Ave</u>				d. STREET ADDRESS <u>120 Smithwood Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>HENRY SPITTEL</u>				4. DATE OF DEATH <u>June 2 1958</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/12/190</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mgr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food Fair</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. R. Spittel</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Virginia Spittel</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 minutes</u> <u>1 yr +</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>1957</u> 19 <u>—</u> to <u>June 2</u> 1958, that I last saw the deceased alive on <u>May 29</u> 1958, and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1115 St Paul St.</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>John A. Nesbitt Jr.</u> M.D. <u>Baltimore 2, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/5/58</u>		<u>London Park</u>		<u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>—</u>				DATE <u>JUN 5 '58</u>		<u>—</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1 **FOR STATE HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Hereford</u>		c. LENGTH OF STAY IN 1b <u>BALTIMORE 3Y01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1607 ST PAUL ST</u>	
3. NAME OF DECEASED (Type or print) <u>Connie P. SPRINKLE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-1916</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION STATESVILLE NC</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>WALTER PARKS SPRINKLE</u>		14. MOTHER'S MAIDEN NAME <u>EUNICE AUSTIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>237-14-0254</u>	
17. INFORMANT <u>Family Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull, Fractured Neck</u> <u>910.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fractured Mandible</u> [a], stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Steel Framework of bridge collapsed &amp; fell on h im.</u>	
20c. TIME OF INJURY Month, Day, Year <u>6/23 1958</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Gunpowder Falls</u>		20f. (City or town) (County) (State) <u>Hereford BALTO. MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/23/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>JUNE 24 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Burns Sons</u>		22d. LOCATION (City, town, or county) (State) <u>STATESVILLE, NORTH CAROLINA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u>	
ADDRESS <u>Towson &amp; Ind.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

6618

Item 1 FilmG230 6-30-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

06607

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>23 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>16 Aigburth Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>Bordley</b> Last <b>Stafford</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1868</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>08</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William C. Bordley</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Heritage</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Chester H. Collison</b>		Address <b>16 Aigburth Rd Towson 4</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X Apoplexy</b> DUE TO (b) <b>Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1948</b> , to <b>21 June 1958</b> , that I last saw the deceased alive on <b>20 June 1958</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Reier</b> M.D.		ADDRESS (Street, city or town, state) <b>6701 York Rd Baltimore 12 Md</b>	
DATE SIGNED <b>21 June 58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/23/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waverly, Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. Weems &amp; Son</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '58</b>	
ADDRESS <b>805 N. Calvert St.</b>		24b. REGISTRAR'S SIGNATURE <b>Reier</b>	







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6619

## CERTIFICATE OF DEATH

Reg. Dist. No. 06608

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>FLORIDA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>4 1/2 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>324 JULIA ST</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARTHA EVELYN STALEY</b>				4. DATE OF DEATH Month Day Year <b>JUNE 2 1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-6-1883</b>		9. AGE (In years last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRACTICAL NURSE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>579-12-2528</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>CHARLES O. IMBREY</b>				14. MOTHER'S MAIDEN NAME <b>MAMANTHA CORBART</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-12-2528</b>		17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2 DUE TO ADENO-CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 1/2 yrs.</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II.—OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-18</b> , 19 <b>54</b> , to <b>5-30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-30</b> , 19 <b>58</b> , and that death occurred at <b>7:10 A.M.</b> , from the causes and on the date stated above. <b>Walter R. Ruse</b> ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>6/2/58</b>							
ACTUAL SIGNATURE				M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>6-3-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mana Sota Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6473

## CERTIFICATE OF DEATH

Reg. Dist. No.

06609

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>230 CLEVELAND STREET</u>		e. STREET ADDRESS <u>230 CLEVELAND AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL T. STANKUS</u>		4. DATE OF DEATH Month Day Year <u>JUNE 23 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAIL OPERATOR BETH STEEL CO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LITHUANIA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John. STANKUS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-0839A</u>	
17. INFORMANT <u>ONA STANKUS</u>		Address <u>230 CLEVELAND ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensive arterioscleortic cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>one hr.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/22/58</u> , 19 <u>58</u> to <u>6/23/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/22/58</u> , 19 <u>58</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Baermann, M.D.</u>		ADDRESS (Street, city or town, state) <u>33 Dundalk Ave. Dundalk 22, Md.</u>	
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-27-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEMPTION</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Sackman</u>		ADDRESS <u>637 Washington St</u>	
24. REC'D BY REGISTRAR <u>June 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Baermann</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6620

## CERTIFICATE OF DEATH

06610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Catonsville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>unknown</u>		<u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>2211 W. Rogers Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora Twiss Stevens</u>		4. DATE OF DEATH Month Day Year <u>June 21 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-78</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dexter Twiss</u>		14. MOTHER'S MAIDEN NAME <u>Helen Truesdale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Pauline Jarboe</u>		Address <u>2211 W. Rogers Ave. Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Several years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 29, 1958</u> , to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 21, 1958</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>		DATE SIGNED <u>6/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Liepmann</u>		24a. REC'D BY REGISTRAR <u>W. J. Liepmann</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Liepmann</u>		DATE <u>JUN 24 '58</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		DATE OF DEATH June 15, 1958	
AGE 45		SEX Male	
RACE White		RELIGION Roman Catholic	
BIRTHPLACE New York, U.S.A.		RESIDENCE 123 Main St., Baltimore, Md.	
OCCUPATION Teacher		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		PLACE OF DEATH Home	
DATE OF BURIAL June 17, 1958		PLACE OF BURIAL St. Mary's Cemetery	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JUDGE	



6621

## CERTIFICATE OF DEATH

06611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Cuba</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havana</b> 03x-1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>405 Dorsey Ave.</b>				El Reparto de Los Pinos <b>El Hogar De Minos</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Etta Faith Stewart</b>				4. DATE OF DEATH Month Day Year <b>June 9, 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1878.</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days <b>3 25</b>	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister of Gospel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church Of God</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Stewart</b>				14. MOTHER'S MAIDEN NAME <b>Anna Stewart</b>			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Rev. Harold Barber 405 Dorsey Ave. Essex.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac standstill</b> <b>290.0</b> DUE TO <b>Anoxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Bernicivous anemia</b> (c) <b>undetermined</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/1, 19 58</b> , to <b>6/9, 19 58</b> , that I last saw the deceased alive on <b>6/7, 19 58</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>434 EASTERN Ave. Essex, Md.</b> DATE SIGNED <b>6/10/58</b> ACTUAL SIGNATURE <b>J. PLATT, M.D.</b> PHYSICIAN'S NAME (Type) <b>J. PLATT, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>JUNE 13-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SANTIAGO DE LOS VEGAS</b>		22d. LOCATION (City, town, or county) (State) <b>Havana, Cuba.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John S. Connelley, Esq., Md.</b>				24a. REC'D BY REGISTRAR DATE <b>6/12/58</b>		24b. REGISTRAR'S SIGNATURE <b>A.W. Hedrick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1902	
AGE		SEX	
65		Male	
PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE, MARYLAND		JAN 15 1837	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Failure	
PLACE OF DEATH		DATE OF DEATH	
BALTIMORE, MARYLAND		JAN 15 1902	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS	
DATE OF DEATH		DATE OF DEATH	
JAN 15 1902		JAN 15 1902	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
NAME OF DECEASED		NAME OF DECEASED	
JAMES H. HARRIS		JAMES H. HARRIS	
AGE		AGE	
65		65	
SEX		SEX	
Male		Male	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BIRTH		DATE OF BIRTH	
JAN 15 1837		JAN 15 1837	
OCCUPATION		OCCUPATION	
Carpenter		Carpenter	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
NAME OF PHYSICIAN		NAME OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS	
DATE OF DEATH		DATE OF DEATH	
JAN 15 1902		JAN 15 1902	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

100-2-20-2

100-2-20-2

6622

CERTIFICATE OF DEATH

Reg. Dist. No. 06612

Item 8, Film G-231 7/7/58, cac.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleyville</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1 Beekleyville</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH - T - STREVIC</u>		4. DATE OF DEATH <u>June 26 1958</u>	
5. SEX <u>OF</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 5 - 1895</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thornton Frank</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Hare</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>R15-01-7129</u>	
17. INFORMANT <u>Russell Strevic</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic nephritis</u> <u>Antimuscleinetic</u> <u>260X</u> DUE TO <u>Redney</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Antimuscleinetic Heart Disease</u> DUE TO <u>Diabetes mellitus</u> (c) <u>7 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>5 yrs</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 18</u> , 19 <u>52</u> to <u>June 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md</u>	
PHYSICIAN'S NAME (Type) <u>W H Foard MD</u>		DATE SIGNED <u>6/26/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-28-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grave Run</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton-Hampstead Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6623

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06613

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Nicodemus Rd. near Gore's Mill Rd.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b> 06x-2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>Deer Park Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Emory</b> Middle <b>Franklin</b> Last <b>Stricker</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1905</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>06</b> Days <b>21</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James C. Stricker</b>		14. MOTHER'S MAIDEN NAME <b>Racheal R. Flater</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.2</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>J. Samuel Stricker, Finksburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull, mandible &amp; both collar bones</b> DUE TO <b>auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>auto accident</b> DUE TO (c) <b>auto accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>10 min.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Truck &amp; truck telephone pole</b>	
20c. TIME OF INJURY Month, Day, Year <b>6-21-58</b> Hour <b>4:15</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Reisterstown Balt. Ind.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D.D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D.D. CAPLES, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6-21-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 24/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		22d. LOCATION (City, town, or county) (State) <b>Gamber, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>JUN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color	
James C. Harrison		35		Male		White		White	
Residence		Occupation		Cause of Death		Manner of Death		Date of Death	
1000 North 1st St. Baltimore, Md.		Police Officer		Heart Disease		Natural		June 11, 1938	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death	
June 11, 1903		Baltimore, Md.		June 11, 1938		June 11, 1938		June 11, 1938	
Signature of Medical Examiner		Signature of Coroner		Signature of Physician		Signature of Nurse		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Name of Medical Examiner		Name of Coroner		Name of Physician		Name of Nurse		Name of Undertaker	
James C. Harrison		James C. Harrison		James C. Harrison		James C. Harrison		James C. Harrison	
Address		Address		Address		Address		Address	
1000 North 1st St. Baltimore, Md.		1000 North 1st St. Baltimore, Md.		1000 North 1st St. Baltimore, Md.		1000 North 1st St. Baltimore, Md.		1000 North 1st St. Baltimore, Md.	
Telephone		Telephone		Telephone		Telephone		Telephone	
[Number]		[Number]		[Number]		[Number]		[Number]	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
June 11, 1938		June 11, 1938		June 11, 1938		June 11, 1938		June 11, 1938	
Time of Death		Time of Death		Time of Death		Time of Death		Time of Death	
[Time]		[Time]		[Time]		[Time]		[Time]	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
Home		Home		Home		Home		Home	
Signature of Medical Examiner		Signature of Coroner		Signature of Physician		Signature of Nurse		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Name of Medical Examiner		Name of Coroner		Name of Physician		Name of Nurse		Name of Undertaker	
James C. Harrison		James C. Harrison		James C. Harrison		James C. Harrison		James C. Harrison	
Address		Address		Address		Address		Address	
1000 North 1st St. Baltimore, Md.		1000 North 1st St. Baltimore, Md.		1000 North 1st St. Baltimore, Md.		1000 North 1st St. Baltimore, Md.		1000 North 1st St. Baltimore, Md.	
Telephone		Telephone		Telephone		Telephone		Telephone	
[Number]		[Number]		[Number]		[Number]		[Number]	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
June 11, 1938		June 11, 1938		June 11, 1938		June 11, 1938		June 11, 1938	
Time of Death		Time of Death		Time of Death		Time of Death		Time of Death	
[Time]		[Time]		[Time]		[Time]		[Time]	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
Home		Home		Home		Home		Home	

6624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> <b>3V01-4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines</b>				d. STREET ADDRESS <b>3312 Woodland Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>L.</b> Last <b>Tall</b>				4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1882</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	IF UNDER 24 HRS. Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Landscapers</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Md.</b>	
13. FATHER'S NAME <b>Joseph L. Tall</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Cauzmall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Anna E. Tall - 3312 Woodland Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vase Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old Left Paralysis</b> (c) <b>Generalized Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 19 39</b> to <b>June 19 58</b> , that I last saw the deceased alive on <b>June 22, 19 58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4509 Liberty Key Ave</b> DATE SIGNED <b>6-23-58</b> ACTUAL SIGNATURE <b>Dr. Thos G Abbott</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Thos G Abbott</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS - Balto. 17, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. H. H. H.</b>	

CERTIFICATE OF DEATH

6234

Page 1 of 1

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>	
<p>3. AGE                  [REDACTED]</p>		<p>4. DATE OF BIRTH                  [REDACTED]</p>	
<p>5. PLACE OF BIRTH                  [REDACTED]</p>		<p>6. OCCUPATION                  [REDACTED]</p>	
<p>7. MARITAL STATUS                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>	
<p>9. MEDICAL HISTORY                  [REDACTED]</p>		<p>10. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>	
<p>11. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>15. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>17. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>21. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>22. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>23. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>25. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>27. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>28. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>29. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>31. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>33. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>34. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>35. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>37. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>39. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>40. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>41. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>43. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>45. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>46. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>47. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>49. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>51. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>52. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>53. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>55. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>57. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>58. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>59. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>61. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>63. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>64. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>65. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>67. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>69. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>70. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>71. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>73. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>75. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>76. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>77. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>79. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>81. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>82. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>83. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>85. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>87. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>88. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>89. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>91. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>93. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>94. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>95. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>97. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>99. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>100. SIGNATURE OF WITNESS                  [REDACTED]</p>	

MD-0000000000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06615

6625

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Ma</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Here Ford</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Frederick</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1890</u> 67 yrs.
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Conowingo Hydro Plant, Birmingham, England, USA</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Birmingham, England, USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Alfred F. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Alice Mc Moorhouse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>164-10-6407</u>	
17. INFORMANT <u>Mrs. Richard F. Taylor</u>		Address <u>Corbett &amp; Matney Road, Monroeville, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 7, 1958</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Harlington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH - BARNHART 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6732

FOR STATE  
DEATH ONLY

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		POST-MORTEM EXAMINATION		OTHER	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF WITNESS		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF JURY		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF JUDGE		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF CLERK		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF SHERIFF		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF CORONER		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF JURY		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF JUDGE		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF CLERK		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF SHERIFF		DATE		PLACE		CITY		COUNTY	
SIGNATURE OF CORONER		DATE		PLACE		CITY		COUNTY	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6626  
CERTIFICATE OF DEATH

Reg. Dist. No. 06616

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen Maria Thomas</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 4, 1866</b>
9. AGE (In years last birthday) <b>92 yrs.</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Principal retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Elias Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Louise MacKnew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Frank L. Thomas, 3200 Offutt Rd. Randallstown</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal aortic aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>5 yrs +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , 19 <b>6-19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-19</b> , 19 <b>58</b> , and that death occurred at <b>3:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1118 St Paul St Baltimore 2, Maryland</b> DATE SIGNED <b></b>			
ACTUAL SIGNATURE <b>John A. Nesbitt, Jr.</b> M.D. <b>1118 St Paul St</b>			
PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>		<b>Baltimore 2, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-23-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Everett Annand</b>		ADDRESS <b>600 Liberty Heights Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUN 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Redmond</b>	

\* \* \* \* \*

74

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6627

## CERTIFICATE OF DEATH

06617

Reg. Dist. No.

1. PLACE OF DEATH <u>Rosewood State Training School</u> o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>Thompson</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/ /36</u>	
9. AGE (In years last birthday) yrs. <u>21</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>? IRA G. THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>? EMELIA CLARK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Rosewood Records</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephrosis, lower nephron</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral palsy &amp; mental deficiency</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5/13/58</u> , 19 <u>  </u> , to <u>6/11/58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>6/11/58</u> , 19 <u>  </u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rich. Liekeberg (P.K.)</u> M.D.				ADDRESS (Street, city or town, state) <u>700 Fleet Street Balto Md</u>			
DATE SIGNED <u>6/12/58</u>							
PHYSICIAN'S NAME (Type) <u>Rich. Liekeberg (P.K.)</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jackson Funeral Home</u>				ADDRESS <u>916</u> <u>PENNA. AVE</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>6 JUN 20 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>							

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6628

## CERTIFICATE OF DEATH

06618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>28yr9mth4dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Goff</b> Last <b>Tracy</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1902</b>	9. AGE (In years last birthday) yrs. <b>56</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>handyman</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>James Tracy</b>			14. MOTHER'S MAIDEN NAME <b>Mary MacDonald</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the stomach</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 10</b> , 19 <b>58</b> , to <b>6/20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/20/58</b> , 19 <b>58</b> , and that death occurred at <b>5:30 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachsler</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6/20/58</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachsler/ M.D.</b>				CATIONSVILLE 28, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6.26.58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wm. H. H. School</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <b>JUL 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1928

Form No. 10

<p>1. Name of deceased (Print or write full name)                  _____</p>		<p>2. Sex                  _____</p>	
<p>3. Date of birth (Month, day, year)                  _____</p>		<p>4. Place of birth (City, State, Country)                  _____</p>	
<p>5. Date of death (Month, day, year)                  _____</p>		<p>6. Place of death (City, State, Country)                  _____</p>	
<p>7. Cause of death (Immediate cause)                  _____</p>		<p>8. Cause of death (Underlying cause)                  _____</p>	
<p>9. Name of physician (Print or write full name)                  _____</p>		<p>10. Name of funeral home (Print or write full name)                  _____</p>	
<p>11. Signature of physician (Print or write full name)                  _____</p>		<p>12. Signature of funeral home (Print or write full name)                  _____</p>	
<p>13. Date of signature (Month, day, year)                  _____</p>		<p>14. Date of signature (Month, day, year)                  _____</p>	

6629

## CERTIFICATE OF DEATH

Reg. Dist. No.

06619

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Parkton</b>				c. LENGTH OF STAY IN 1b <b>41 yrs.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stablersville Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>TUSZYNSKI</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1958</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1874</b>	9. AGE (In years and birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Poland.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>								
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Peter Tuszynski,</b>		Address <b>Parkton, Md. R. D.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arterio-Sclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>10 yrs</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
			20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from <b>April 10, 1958</b> , to <b>June 28, 1958</b> , that I last saw the deceased alive on <b>June 28, 1958</b> , and that death occurred at <b>4:50 P. M.</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Milner Bortner</b>			ADDRESS (Street, city or town, state) <b>White Hall, Md.</b>		DATE SIGNED <b>6/30/58</b>			
PHYSICIAN'S NAME (Type) <b>Milner Bortner</b>			<b>White Hall, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 2, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Jacob Hartenstein</b>			ADDRESS <b>New Freedom, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Reg. Dist. No.

1. Name of deceased (Print or write full name, including maiden name, if known)

Baltimore

Maryland

Married

Baltimore

Place of birth

Anna - Parkson

Al. vis.

Anna - Parkson

Stadleraville Rd.

Stadleraville Rd.

TUESDAY

JACOB

Male

White

July 12, 1874

Age

U. S. A.

Poland

Own farm

Farmer

Unknown

Unknown

No

Peter Tuszynski

Parkson, Md., U. S. D.

Md.

Baltimore

July 2, 1922

Anna

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6630 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>			c. LENGTH OF STAY IN 1b <b>50 yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>347 Uppland Rd.</b>				d. STREET ADDRESS <b>1 347 Uppland Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>UHL</b> Last <b>UHL</b>				4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>Fe</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1 - 1877</b>	
				9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min. <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-keeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AT-Home</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>Charles Klutsch</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>213-12-0832</b>		17. INFORMANT <b>Robert UHL - SAME</b>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart dis.</b> DUE TO (c) <b>10 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>June 27-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Schwartz Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly - Essex - Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Smith</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

DATE

TIME

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

DATE OF ARRIVAL

DATE OF DEATH

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6474

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b>				c. LENGTH OF STAY IN 1b <b>53 DUNDALK 22</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7949 Saint Bridget Lane</b>				d. STREET ADDRESS <b>7949 Saint Bridget Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Vechio</b> Last <b>Vechio</b>				4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 1, 1867</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevador (ret'd)</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Michael Vechio, 7949 Saint Bridget Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>0</b> a. m. <b>0</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6/23/58</b>	
20f. (City or town) <b>6/23/58</b>				20g. (County) <b>6/23/58</b>		20h. (State) <b>6/23/58</b>	
21. I certify that I attended the deceased from <b>6/23/58</b> 19, to <b>6/23/58</b> 19, that I last saw the deceased alive on <b>6/23/58</b> 19, and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2503 W. Woodland Rd. Baltimore, Md.</b> DATE SIGNED <b>6/25/58</b>							
ACTUAL SIGNATURE <b>Oswald B. Ferris</b>				PHYSICIAN'S NAME (Type) <b>Oswald B. Ferris MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-25-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6631

Item 5 Film 230 6-12-58 et

## CERTIFICATE OF DEATH

06622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balt.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lochearn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lochearn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6218 Liberty Heights Terrace</b>		d. STREET ADDRESS <b>6218 Liberty Heights Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John W. Wagner</b>		4. DATE OF DEATH <b>June 6, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assessor</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Louis P. Wagner</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Hoerr</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lina B. Wagner</b> Address <b>6218 Liberty Heights Terrace</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 1957</b> to <b>June 1958</b> , that I last saw the deceased alive on <b>6 June 1958</b> and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2 June 1958</b>			
ACTUAL SIGNATURE <b>Marvin H. Davis</b> M.D.		PHYSICIAN'S NAME (Type) <b>Marvin H. Davis M.D.</b> <b>6512 Liberty Road Baltimore Co. Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 11, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zoar Baptist Church</b>	22d. LOCATION (City, town, or county) (State) <b>Deltaville, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b> ADDRESS <b>1900 Butaw Place</b>		24a. REC'D BY REGISTRAR <b>JUN 9 '58</b>	24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6632

## CERTIFICATE OF DEATH

Reg. Dist. No. **06623**

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8640 Willow Oak Rd.</u>				d. STREET ADDRESS <u>8640 Willow Oak Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Peter</u> Middle <u>J.</u> Last <u>Ward</u> Sr.				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>24</u> Year <u>1958</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 10, 1872</u>		9. AGE (In years last birthday) <u>85 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hatmaker- Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? 		
13. FATHER'S NAME <u>John Ward</u>				14. MOTHER'S MAIDEN NAME <u>Rose McGuire</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT Address <u>Edw. J. Ward 8640 Willow Oak Rd.</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arterio-sclerosis</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/15, 1955</u> , to <u>6/24, 1958</u> , that I last saw the deceased alive on <u>6/24, 1958</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Gordon Grau</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8513 Loch Raven Blvd 6/15/58</u>				
PHYSICIAN'S NAME (Type) <u>GORDON GRAU MD</u>				<u>8513 LOCH RAVEN BLVD TOWSON MD</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Farley Funeral Home Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6633

## CERTIFICATE OF DEATH

Reg. Dist. No.

06624

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b>		d. STREET ADDRESS <b>3501 W. Franklin St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CAROLINE</b> Middle <b>WATSON</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hasz</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edwin Watson Jr.</b>		Address <b>3501 W. Franklin St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR thrombosis</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY</b> , 19 <b>58</b> , to <b>JUNE 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JUNE 16</b> , 19 <b>58</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6014 Edmondson Ave. 6-17-58</b> ACTUAL SIGNATURE <b>J. Nelson McKay M.D.</b> PHYSICIAN'S NAME (Type) <b>J. Nelson McKay M.D. 6014 Edmondson Ave. BALTO 28MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 18 '58</b>	
ADDRESS <b>4101 Edmondson Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Witzke</b>	



6634

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>14 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2526 Garrett Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD A. WELLS</b>				4. DATE OF DEATH Month Day Year <b>June 29 19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 7, 1916</b>	
9. AGE (In years last birthday) <b>42 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Apartment House</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Lloyd Wells</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-01-5548</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 PARTIAL CORONARY OCCLUSION</b> DUE TO <b>SEVERE CORONARY ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15</b> , 19 <b>58</b> , to <b>June 29</b> , 19 <b>58</b> , and that death occurred at <b>9:35 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/30/58</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b>							
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-3-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary</b>		ADDRESS <b>802 Madison Ave. Baltimore 1, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Seuch</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MADE IN U.S.A.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 10

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06626

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6825 Holabird Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b> d. STREET ADDRESS <b>6825 Holabird Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Harry</b> Middle <b>C.</b> Last <b>Wenig</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>3</b> , Year <b>1958</b>													
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>September 29, 1897</b>		<b>9. AGE</b> (In years last birthday) <b>60</b> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Asst. Foreman</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Shipyard</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>George Wenig</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Lena Homberg</b>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mrs. Nellie Wenig, 6825 Holabird Avenue</b>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Myocardial Infarction</b>  <b>420.1</b> DUE TO             </td> <td rowspan="3" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>Immediately</b>    <b>approx. 15 yr.</b> </td> </tr> <tr> <td colspan="2">               Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.             </td> </tr> <tr> <td colspan="2"> <b>(b) Hypertensive Cardio Vascular Disease</b>                DUE TO             </td> </tr> <tr> <td colspan="2"> <b>(c)</b> </td> <td></td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Myocardial Infarction</b> <b>420.1</b> DUE TO		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Immediately</b>  <b>approx. 15 yr.</b>	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<b>(b) Hypertensive Cardio Vascular Disease</b> DUE TO		<b>(c)</b>		
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Myocardial Infarction</b> <b>420.1</b> DUE TO		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Immediately</b>  <b>approx. 15 yr.</b>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
<b>(b) Hypertensive Cardio Vascular Disease</b> DUE TO																	
<b>(c)</b>																	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>none</b>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> <b>Not while</b> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <i>W.E. Baermann</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>4 June 1958</b>													
<b>EXAMINER'S NAME</b> (Type) <b>W.E. BAERMANN, M.D.</b>		<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>															
<b>22b. DATE THEREOF</b> <b>June 6, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Lawn Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Balto. Co., Md.</b>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Ullrich Funeral Home, Dundalk, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> DATE <b>JUN 5 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Albert...</i>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06627

6483

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Arbutus</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4415 Wilkens Avenue</b>		d. STREET ADDRESS <b>4415 Wilkens Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>STEPHEN E. WHARTON</b>		4. DATE OF DEATH <b>June 21 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-24-1899</b>
9. AGE (in years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinest</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal Maryland</b>	
13. BIRTHPLACE (State or foreign country) <b>U.S.</b>		14. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
15. FATHER'S NAME <b>Edward S</b>		16. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>Unknown</b>	
19. INFORMANT <b>Edward S. Wharton</b>		Address <b>1003 Hallimont Rd. #28</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>983X Craniocerebral Injury.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>983X</b> (a), stating the underlying cause last. (c) <b>983X</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>983X</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Beaten on head during altercation.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6/21 1958</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Baltimore Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/23/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-26-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Avenue</b>	
24a. REC'D BY REGISTRAR <b>JUN 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Search</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Howard H. Hubbard		41		Male		White		Caucasian		Protestant		Single		None		Heart Disease		Home		April 10, 1909		10:30 AM		[Signature]		[Signature]		[Signature]	
Residence		Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Reinterment		Date of Reinterment		Date of Reinterment		Date of Reinterment		Date of Reinterment		Date of Reinterment	
Baltimore, Md.		Baltimore, Md.		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909	
Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar	
Heart Disease		Home		April 10, 1909		10:30 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Residence		Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Reinterment		Date of Reinterment		Date of Reinterment		Date of Reinterment		Date of Reinterment		Date of Reinterment	
Baltimore, Md.		Baltimore, Md.		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909		April 10, 1909	
Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar		Signature of Registrar	
Heart Disease		Home		April 10, 1909		10:30 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6635

## CERTIFICATE OF DEATH

Reg. Dist. No. 06628

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX 21</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex 21</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>511 N. Marlyn Avenue</b>				d. STREET ADDRESS <b>511 N. Marlyn Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>G.</b> Last <b>Whitacre</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 23, 1931</b>	
9. AGE (In years last birthday) yrs. <b>27</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PLAINFIELD, N.J.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Corcoran</b>				14. MOTHER'S MAIDEN NAME <b>Alice Wolfe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert J. Whitacre, 511 N. Marlyn Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral neoplasm vs.</b> DUE TO (c) <b>Aneurysm</b> INTERVAL BETWEEN ONSET AND DEATH <b>10-15 MINS.</b> <b>indetermined</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1951</b> to <b>6/8, 1958</b> , that I last saw the deceased alive on <b>6/6, 1958</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>424 Eastern Ave</b> DATE SIGNED <b>6/8/58</b> ACTUAL SIGNATURE <b>J. Platt</b> M.D. <b>Essy md</b> PHYSICIAN'S NAME (Type) <b>J. PLATT, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6636

## CERTIFICATE OF DEATH

Reg. Dist. No. 06629

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>WILHELM</b>		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1880</b>
9. AGE (In years last birthday) yrs. <b>78</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Frank Wilhelm</b>		14. MOTHER'S MAIDEN NAME <b>Kate W. Gross</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Wm. E. Koons - 10 W. Biddle St.</b>	
17. INFORMANT <b>Wm. E. Koons - 10 W. Biddle St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO <b>443x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE C.V. DISEASE -</b> DUE TO <b>10 YEARS</b> (c) <b>SEVERE - CARDIAC ENLARG -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 1, 1955</b> to <b>JUNE 9, 1958</b> , that I last saw the deceased alive on <b>JUNE 9, 1958</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas E. Wheeler</b>		ADDRESS (Street, city or town, state) <b>3601 Clapham Rd Baltimore 5 Md</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS E. WHEELER</b>		DATE SIGNED <b>6/10/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		24a. REG'D BY REGISTRAR <b>JUN 13 58</b>	
ADDRESS <b>Ellsworth Armacost-4600 Liberty Heights Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Koons</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4/4/68	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
MEMPHIS, TENN.		12/21/32		MEMPHIS, TENN.		4/4/68		10:00 PM	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE		DATE		DATE	
4/4/68		4/4/68		4/4/68		4/4/68		4/4/68	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6637

## CERTIFICATE OF DEATH

Reg. Dist. No.

06630

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 52</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>304 Winters Lane</b>		d. STREET ADDRESS <b>304 Winters Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>B.</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>58</b> Min.	IF UNDER 24 HRS. Hours <b>58</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank Dorsey</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Clark</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Laura Williams</b> Address <b>304 Winters Lane</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arterio-sclerotic Disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>95 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 3rd 1958</b> , to <b>June 6th 1958</b> , that I last saw the deceased alive on <b>June 6th 1958</b> , and that death occurred at <b>6</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Winters Lane</b> DATE SIGNED <b>6/6/58</b>			
ACTUAL SIGNATURE <b>C.F. Maloney, M.D.</b>		PHYSICIAN'S NAME (Type) <b>C.F. Maloney, M.D. Catonsville, 28. Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Liberty</b>	22d. LOCATION (City, town, or county) (State) <b>Howard Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Miss E. A. Stanley</b>		24a. REC'D BY REGISTRAR <b>5784</b>	24b. REGISTRAR'S SIGNATURE <b>June 11 '58</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6638

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>12 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LORENZO</b> Middle <b>---</b> Last <b>WILSON</b>		4. DATE OF DEATH <b>June</b> Month <b>5</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 9, 1900</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>58</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City</b>	
11. BIRTHPLACE (State or foreign country) <b>Bible County, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lorenzo Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Harriett MN: Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CIRRHOSIS OF THE LIVER.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>May 19</b> Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>May 24</b> 19 <b>58</b> , to <b>June 5</b> 19 <b>58</b> , and that death occurred at <b>10:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/6/58</b>			
ACTUAL SIGNATURE <b>Irving Freeman</b>		PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-9-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b> ADDRESS <b>802-04 Madison Ave. Baltimore 1, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 10 '58</b> DATE <b>6/6/58</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

NAME		Baltimore	
SEX		Male	
AGE		19	
DATE OF BIRTH		1919	
PLACE OF BIRTH		Baltimore, Md.	
OCCUPATION		Student	
CAUSE OF DEATH		Pneumonia	
DATE OF DEATH		1938	
PLACE OF DEATH		Baltimore, Md.	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF CORONER		[Signature]	
SIGNATURE OF DEATH REGISTRAR		[Signature]	
SIGNATURE OF MORTUARY		[Signature]	
SIGNATURE OF BURIAL		[Signature]	
SIGNATURE OF INTERMENT		[Signature]	
SIGNATURE OF FUNERAL HOME		[Signature]	
SIGNATURE OF CEMETERY		[Signature]	
SIGNATURE OF CHURCH		[Signature]	
SIGNATURE OF MINISTRY		[Signature]	
SIGNATURE OF OTHER		[Signature]	

STAIN FOLD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6639 Items 1, 8, 9 Film G230 6-18-58 et  
CERTIFICATE OF DEATH

06632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jennings, Maryland</b>		3. NAME OF DECEASED (Type or print) First <b>Michel</b> Middle <b>Loman</b> Last <b>Wilt</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>19 58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/7/57 (Correct)</b>	
9. AGE (In years last birthday) <b>11</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>26</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Loman Wilt (See birth Cert.)</b>				14. MOTHER'S MAIDEN NAME <b>Rita Bittner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Rosewood Records</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> <b>751x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hydrocephalus and</b> DUE TO (c) <b>meningococle</b>						INTERVAL BETWEEN ONSET AND DEATH <b>one month</b> <del>one month</del> <b>Birth</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>492x (blank)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1</b> , 19 <b>58</b> , to <b>June 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 2</b> , 19 <b>58</b> , and that death occurred at <b>7:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Owings Mills, Md 31</b> DATE SIGNED <b>June 5</b>							
ACTUAL SIGNATURE <b>Harry G. Butler</b>		M.D. <b>Owings Mills, Md</b>					
PHYSICIAN'S NAME (Type) <b>HARRY G. BUTLER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/4/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BITTINGER</b>		22d. LOCATION (City, town, or county) (State) <b>BITTINGER GARRETT Co MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don Newman</b>				ADDRESS <b>Frederick, Md</b>		24a. REC'D BY REGISTRAR <b>JUN 5 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

CERTIFICATE OF DEATH

8733

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text on the left side.





6640

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>134 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3 v o l - 4</b>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>L.</b> Last <b>WIMPLING</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1893</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician-unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Andrew Wimpling</b>		14. MOTHER'S MAIDEN NAME <b>Kate Faye</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LYMPHOSARCOMA, GENERALIZED</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>15 MONTHS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>January 3, 1958, to June 17, 1958</b> and that death occurred at <b>9:55 P.M.</b> from the causes and on the date stated above. <b>XXXXXX</b>			
ACTUAL SIGNATURE <b>Charles T. Fitch</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES T. FITCH, M.D.</b>		DATE SIGNED <b>6/18/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Cowan and Sons, Hollins and Poppleton, Balto.</b>		24a. REC'D BY REGISTRAR <b>JUN 19 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6641

## CERTIFICATE OF DEATH

Reg. Dist. No.

06634

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>		d. STREET ADDRESS <b>Glenarm Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Sister Mary</b> Middle <b>Alphonsina</b> Last <b>Winkler</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1862</b>
9. AGE (In years last birthday) <b>96</b>		IF UNDER 1 YEAR Months <b>96</b>	IF UNDER 24 HRS. Hours <b>96</b> Min. <b>96</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Joseph</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Gauges</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sister M. Peter Fourier</b>		Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensation</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio vascular renal disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April</b> , 19 <b>52</b> , to <b>June</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>April 22</b> , 19 <b>58</b> , and that death occurred at <b>8:35 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7501 York Road Towson, 4, Md. 6/6/58</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-9-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NR TOWSON, MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Geiler</i>		ADDRESS <b>901 S. CONKLING ST. BALTO, 24, MD.</b>	24a. REC'D BY REGISTRAR <b>901 58</b>
		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG230 6-10-58 et

## CERTIFICATE OF DEATH

06635

6476

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>22</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7407 Waymouth Way</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk 22</b> d. STREET ADDRESS <b>7407 Waymouth Way</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Winks</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1907</b>
9. AGE (In years last birthday) yrs. <b>50</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tractor Driver</b>	
11. BIRTHPLACE (State or foreign country) <b>Knoxville, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas Winks</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Corder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.11 218-01-8842</b>	
17. INFORMANT <b>Mr. Ryder, 7407 Waymouth Way, DUNDALK 22</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> DUE TO <b>Ch of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>141</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-26</b> 19 <b>58</b> to <b>6-1</b> 19 <b>58</b> that I last saw the deceased alive on <b>6-1</b> 19 <b>58</b> , and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sack &amp; Collins</b>		DATE SIGNED <b>2 KINSHIP BAL 22 6-2-58</b>	
PHYSICIAN'S NAME (Type) <b>Sack &amp; Collins</b>		ADDRESS (Street, city or town, State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-5-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>JUN 4 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Reed</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

TIME

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

DATE OF MARRIAGE

NAME OF DECEASED

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CERTIFICATE OF DEATH

06636

Reg. Dist. No.

6642

1. PLACE OF DEATH o. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>FLORIDA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEL REY BEACH FLA</b>	
c. LENGTH OF STAY IN 1b <b>26 Yrs.</b>		d. STREET ADDRESS <b>" 48X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HUGSBURG HOME.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>WOLF</b> Last <b>WOLF</b>		4. DATE OF DEATH <b>6/11/58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 22 1861</b>
9. AGE (In years last birthday) <b>96</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CHRISTIAN WOLF</b>		14. MOTHER'S MAIDEN NAME <b>DOROTHY ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>RECORDS AUG. HOME</b>		Address <b>6811 CAMPFIELD RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart</b> <b>420.0</b> DUE TO <b>Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arterio-sclerosis.</b> (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/24</b> , 19 <b>47</b> , to <b>6/11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 11</b> , 19 <b>58</b> , and that death occurred at <b>8 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Chambers</b>		ADDRESS (Street, city or town, state) <b>4108 Liberty Hts Baltimore - 7 - Md</b> DATE SIGNED <b>6-13-58</b>	
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers -</b>		<b>4108 Liberty Hts Balto. - 7 - md 6-13-58</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/14/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>IMMANUEL</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>PAUL F. MEYERMAN</b> ADDRESS <b>6067 HARE RD</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 16 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6643

CERTIFICATE OF DEATH

06637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALT. CITY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	c. LENGTH OF STAY IN 1b <b>5 years 3 m. 22 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3 Vo 1-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE ST. HOSP.</b>		e. STREET ADDRESS <b>1624 ME. Royal Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>GRACE</b> Last <b>WRIGHT</b>		4. DATE OF DEATH Month <b>6</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-24-1885</b>
9. AGE (In years lost birthday) <b>73</b> yrs		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNSYLVANIA</b>	11. BIRTHPLACE (State or foreign country) <b>U.S.</b>
13. FATHER'S NAME <b>JOHN F. ZIMMERMAN</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE BROGAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Y</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. ELIZABETH KEECH</b>		Address <b>183 Sanford St. Glen Falls N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Esophageal obstruction</b> <b>202.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malignant lymphoma of neck</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease (old)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>4 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/1</b> , 1953, to <b>6/28</b> , 1958, that I last saw the deceased alive on <b>6-28-1958</b> , and that death occurred at <b>6:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bruno Radauskas</b>		ADDRESS (Street, city or town, state) <b>Spring Grove St. Hospital Catonsville 28, Md.</b>	
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>		DATE SIGNED <b>6/29/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 1/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 29 Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b>		ADDRESS <b>4101 Edmondson Ave</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Smith</b>	

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1963

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CITY

STATE

COUNTY

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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JOHN F. SHAMMARNAN

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6644

## CERTIFICATE OF DEATH

06638

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-WOODLAWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-WOODLAWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1919 FEATHER BED LANE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>ADOLPH</u> Last <u>ZEIGLER</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 9, 1871</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE F. ZEIGLER</u>				14. MOTHER'S MAIDEN NAME <u>WEIDEMEYER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (SON) <u>HENRY ZEIGLER</u> Address <u>1919 FEATHER BED LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>CONGESTIVE HEART FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>2 YEARS</u> <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 16, 1954</u> , to <u>JUNE 2, 1958</u> , that I last saw the deceased alive on <u>MAY 31, 1958</u> , and that death occurred at <u>1:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.				ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD BALTO. 7, Md.</u> DATE SIGNED <u>6/2/58</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>				<u>BALTO. 7, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>RANDALSTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. STANISBURY</u> ADDRESS <u>WOODLAWN MD</u>				24a. REC'D BY REGISTRAR <u>JUN 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	



THE UNIVERSITY OF CHICAGO PRESS